

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4047 Botanical
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME **Beulah B. Westervelt**

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Edw. R. Westervelt.** 6. (c) Age of husband or wife if alive **67** years

7. Birth date of deceased **December 7, 1872**
(Month) (Day) (Year)

8. AGE: Years **67** Months **10** Days **19** If less than one day hr. _____ min. _____

9. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **H. W.**

11. Industry or business _____

MOTHER FATHER { 12. Name **James L. Neville.**

18. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary L. French.**

16. Birthplace **Missouri.**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Eva Edw R. Westervelt**

(b) Address **4047 Botanical.**

17. (a) **Burial** (b) Date thereof **OCT 29-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Paducah, Ky**

18. (a) Signature of funeral director **Boyer Underwood**

(b) Address **131 W. Argonne Kirkwood**

19. (a) **OCT 27 1940** (b) _____
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL") **17**
(d) Street No. **4047 Botanical.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **26**
year **1940** hour **5am** minute _____ M.

21. I hereby certify that I attended the deceased from **October 19,** 19 **40** to **October 25,** 19 **40**;
that I last saw her alive on **October 25,** 19 **40**;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Cerebral Hemorrhage
Due to **Arterio-sclerosis**
Hypertension

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(e) Means of injury **3**

23. Signature **William Seibert** M.D. or other D.O. **3**
Address **5 S. Moranc, Clayton, Mo.** Date signed **10/26/40**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

John M Meyer
working under my personal supervision.

....., Registered Apprentice No.....

Signed *John M Meyer*

Licensed Embalmer No. *3288*

P. O. Address *340 W. Adams St
Berks*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.