

No. 2
1-10-39
17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **39730**
Registrar's No. **2160**

Registration District No. **784**

Primary Registration District No. **200**

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town COON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ROBERT KOCH HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 183 days
(Specify whether
In this community years, months or days) 1

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS
(c) City or town BRENTWOOD
(If outside city or town limit write "RURAL")
(d) Street No. 9017 W. PINE
(If rural, give location)
(e) If foreign born, how long in U. S. A.?
0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER day 14
year 1940 hour 6 minute 30 P. M.
21. I hereby certify that I attended the deceased from
MAY 15 1940 to NOVEMBER 14 1940
that I last saw him alive on NOVEMBER 14 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
CHRONIC PULMONARY
TUBERCULOSIS

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

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

23. Signature [Signature] (M. D. or other)
Address Koch Hosp Date signed 11/15/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME BERT BEHYMER

3. (b) If veteran, name war
3. (c) Social Security No. None

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife CARRIE (DEAD) 6. (c) Age of husband or wife if alive 22 years

7. Birth date of deceased MARCH 22 1874
(Month) (Day) (Year)

8. AGE: Years 66 Months 7 Days 23 If less than one day hr. min.

9. Birthplace MILLSHOALS ILLINOIS
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business 1

12. Name JOHN BEHYMER

13. Birthplace OHIO
(City, town, or county) (State or foreign country)

14. Maiden name JANINA BEEMAN

15. Birthplace INDIANA
(City, town, or county) (State or foreign country)

16. (a) Informant KOCH RECORDS
(b) Address Koch Hos.

17. (a) Removal (b) Date thereof 11 18 41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Fairfield ILL

18. (a) Signature of funeral director [Signature]
(b) Address Fairfield ILL

19. (a) NOV 15 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

(Licensed Embalmers' Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILE DEC 7

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.....

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

working under my personal supervision.

Signed.....

Licensed Embalmer No. 3880

P. O. Address.....

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

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