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3-40  
7-39  
X2315

JAN 8 1941

State File No. \_\_\_\_\_

Registration District No. 784

Primary Registration District No. 101

Registrar's No. 2321

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St. Louis Co. Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days  
(Specify whether years, months or days)

In this community 14 months (Specify whether years, months or days)

3. (a) PRINT FULL NAME Irene Beasley

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Edward Cecil Beasley

6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased March 1st 1905  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>35</u>	<u>9</u>	<u>6</u>	hr. _____ min.

9. Birthplace Beloxie, Miss  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Lee Howell

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

14. Maiden name Sally Wyatt

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

16. (a) Informant Hospital record

(b) Address St. Lu. Co. Hospital

17. (a) Burial (b) Date thereof 12-10-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Geo. L. Pleitsch Inc.

(b) Address 5966-68 Easton Ave.

19. (a) DEC 9 1940 (b) J. R. Myer  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis

(c) City or town Wellston  
(If outside city or town limits, write "RURAL")

(d) Street No. 6202 Ridge  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? Life years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 7 year 1940 hour 4 minute 25 M.

21. I hereby certify that I attended the deceased from 12-3-40, 1940, to 12-7, 1940 that I last saw her alive on Dec 3, 4, 5, 6, & 7th, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Ca of Pericardium with wide spread metastasis

Duration 17 Mo

Due to \_\_\_\_\_

Due to 48

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy Ca of Pericardium with metastasis

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

23. Signature B. S. Stehman (M. D. or other) M.D.

Address St. Louis Co. Hospital Date signed 12-7-40

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

MOTHER FATHER

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**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 3454

David C. Gibson, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed David C. Gibson

Licensed Embalmer No. 3454

P. O. Address 5966 Easton St. Home

**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, fact should be so stated above.**