

FILLED NOV 11 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36174

State File No. _____

Registration District No. 787

Primary Registration District No. 200

Registrar's No. 2243

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Germany
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Rose Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10/28/41 to 11/5/41
(Specify whether
In this community _____
years, months or days)

8. (a) PRINT FULL NAME Charles Louis Beer

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 12 1910
(Month) (Day) (Year)

8. AGE: Years 31 Months 4 Days 23 If less than one day _____ hr. _____ min.

9. Birthplace Germany, Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business

MOTHER FATHER
12. Name John Beer
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Cassia Beer
15. Birthplace Wallaoui
(City, town, or county) (State or foreign country)

16. (a) Informant George Beer
(b) Address Germany, Ill

17. (a) Removal (b) Date thereof 11-6-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Germany, Ill

18. (a) Signature of funeral director Robert W. Adge

(b) Address 4700 Washington St.

19. (a) NOV 6 1941 (b) C. D. Mc Larson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Clenton
(c) City or town Germany
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 21 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month November day 5
year 1941 hour 7 minute 40 A. M.

21. I hereby certify that I attended the deceased from Oct. 28
1941, to Nov. 5 1941;
that I last saw her alive on Nov. 5 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Far Advanced Pulmonary Tuberculosis
Due to _____

Due to 13/11
Other conditions Tbc Enteritis
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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)
Means of injury 0

23. Signature Alfred C. Kunkle M.D. (M. D. or other)
Address 607 N. Grand St. Date signed 11/6/41

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

7600

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 Albert H. Happel

Licensed Embalmer No. 1861

P. O. Address _____

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.