

FILED MAR 15 1945
 318

Registration District No.

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:
 (a) County.....
 (b) City or town..... St. Louis
 (c) Name of hospital or institution: Enroute to City Hospital
 (d) Length of stay: In hospital or institution.....
 In this community.....

2. USUAL RESIDENCE OF DECEASED: 000
 (a) State..... Missouri (b) County.....
 (c) City or town..... St. Louis
 (d) Street No..... 4229 West Pine Blvd.
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME Orville Howard Beadles
 (b) If veteran, name war Nil
 (c) Social Security No. 493-01-4571

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month March day 1
 year 1945 hour 7 minute 26 P.M.
 21. I hereby certify that I attended the deceased from.....
 that I last saw h..... alive on.....
 and that death occurred on the date and hour stated above.

4. Sex Male Male
 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (c) Age of husband or wife if alive 56 years
 7. Birth date of deceased May 15 1887

Immediate cause of death.....
 Chronic Endocarditis
 Chronic Myocarditis
 Other conditions.....
 (Include pregnancy within 3 months of death)

8. AGE:	Years	Months	Days	If less than one day
	57	9	16 hr. min.

9. Birthplace Decatur Illinois
 10. Usual occupation Salesman

11. Industry or business.....
 12. Name Howard Beadles
 13. Birthplace Unknown Illinois
 14. Maiden name Cora Baldrige
 15. Birthplace Unknown Illinois

16. (a) Informant Winnie Beadles
 (b) Address St. Frances Hotel, 604 Chestnut
 17. (a) Burial (b) Date thereof 3-3-45
 (c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Albert H. Hoppe
 (b) Address 4700 Washington Blvd.
 19. (a) MAR 2 1945 (b) (Registrar's signature)

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?.....
 (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..... (M. D. or other)
 Address..... Date signed 3/2/45

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

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

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..... *H. W. Wilkin*
.....
Licensed Embalmer No..... *3575*

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, fact should be so stated above.