

Registration District No. **010**

Primary Registration District No. **3058**

1. PLACE OF DEATH:

(a) County **St. Charles**
(b) City or town **St. Charles**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Weeks** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Charles**
(c) City or town **St. Charles**
(If outside city or town limits, write "RURAL")
(d) Street No. **709 Monroe Street**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **Louis Beimdiak**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **493-03-5911**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Emma Meyer** 6. (c) Age of husband or wife if alive **2** years
7. Birth date of deceased **July 6th, 1873**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	74	3	0	hr. min.

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

10. Usual occupation

11. Industry or business **American Car & Foundry Co.**

12. Name **Henry W. Beimdiak**

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

14. Maiden name **Louise Siek**

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

16. (a) Informant **Alma Beimdiak**

(b) Address **726 Adams Str., St. Charles, Mo.**

17. (a) **Burial** (b) Date thereof **Oct. 8, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Friedens Cemetery**

18. (a) Signature of funeral director **Haeckmann - Pau**

(b) Address **326 N. 6th. Str., St. Charles, Mo.**

19. (a) **11-4-47** (b) **Francis Haeckmann**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **6** year **1947** hour **2** minute **30** A.M.
21. I hereby certify that I attended the deceased from **9/15/47** to **10-10-47**
that I last saw h. **i** alive on **Oct 6** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**
Due to **Gen. arteriosclerosis**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **53A** 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) (a) Means of injury **0**
Signature **R. B. ...** (M. D. or other) **0**
Address **126 S. Main St.** Date signed **10/6/47**

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

MOTHER FATHER

Date Filed 11-12-47

District File Number _____

District Health Officer No. 9

RECEIVED

MAR 18 1948

MAR 20 1948

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 Arthur C. Bane

Licensed Embalmer No. 3155

P. O. Address St Charles, Mo.

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.