V. S. No. 2
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ev. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED FEB 20 1948 318
Registration District No.

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 6063

Registrar's No. 1316

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

1. PLACE OF DEATH:
(a) County ~~St. Louis~~
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Christian Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days (Specify whether years, months or days)
In this community 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3409 North Florissant
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -------

3. (a) PRINT FULL NAME Mrs. Dovie Besher
3. (b) If veteran, name war -----
3. (c) Social Security No. -----
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife William Besher
6. (c) Age of husband or wife if alive 42 years
7. Birth date of deceased November (Month) 13, (Day) 1906 (Year)

8. AGE: Years	Months	Days	If less than one day
41	2	24	hr. min.

9. Birthplace Cairo, (City, town, or county) Illinois (State or foreign country)
10. Usual occupation At Home
11. Industry or business -----
FATHER
12. Name Jesse McCrite
13. Birthplace Alexander County, (City, town, or county) Illinois (State or foreign country)
MOTHER
14. Maiden name Frances Barnwell
15. Birthplace Illinois (City, town, or county) (State or foreign country)
16. (a) Informant Mr. William Besher
(b) Address 3409 North Florissant
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/48 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cem.
18. (a) Signature of funeral director Beiderwieden F. Hl., Inc.
(b) Address 1936 St. Louis Avenue
19. (a) FEB 9 1948 (Date received local registrar) (b) J. F. Bresnick (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month February day 7, year 1948 hour 1: minute 25 A.M.
21. I hereby certify that I attended the deceased from 11-21-45, 19, to 2-7, 19 48 that I last saw him alive on 2-7-48, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: generalized carcinomatosis originating in	
Due to: sigmoid colon	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature HARRY A. KLEIN, M.D. (M.D. or other) M.D.
Address 5074 N. Union Blvd. Date signed 2-7-48
St. Louis 15, Mo.

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

5074 Main

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 Glen W. Hay

Licensed Embalmer No. 3737

P. O. Address 1936 N. Lewis Ln

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.