

FILED OCT 23 1948

Registration District No. ....

Primary Registration District No. .... 1003

Registrar's No. ....

1. PLACE OF DEATH:

(a) County.....  
(b) City or town..... **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution..... **State Hospital, St. Louis**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... **36 years**  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME..... **MAX BECKER**

3. (b) If veteran, name war..... 3. (c) Social Security No. ....

4. Sex..... **M. O.** 5. Color or race..... **W. S.** 6. (a) Single, widowed, married, divorced..... **S. O.**  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased..... **Dec. 4th., 1896**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**51 10 8** ..hr. ....min

9. Birthplace..... **N.Y.**  
(City, town, or county) (State or foreign country)

10. Usual occupation..... **Nil**

11. Industry or business.....

12. Name..... **Jacob Becker**

13. Birthplace..... **Austria 4**  
(City, town, or county) (State or foreign country)

14. Maiden name..... **Rebecca Dorn**

15. Birthplace..... **Poland 4**  
(City, town, or county) (State or foreign country)

16. (a) Informant..... **Mr. Edward Becker**

(b) Address..... **3804 West Pine Blvd.**

17. (a) Burial, cremation, or removal..... **Burial** (b) Date thereof..... **10-14-48**  
(Month) (Day) (Year)

(c) Place: burial or cremation..... **Chesed Shel Emet Cen. Oxenhandler**

18. (a) Signature of funeral director..... **[Signature]**  
(b) Address..... **5016 Bright Avenue**

19. (a) **OCT 13 1948** (b) **[Signature]**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Mo.** (b) County..... **000**  
(c) City or town..... **St. Louis 17**  
(If outside city or town limits, write "RURAL")  
(d) Street No..... **5300 Arsenal St. 9**  
(If rural, give location)  
(e) Citizen of foreign country?..... **13 0** (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... **October** day..... **12**  
year..... **1948** hour..... **3:10** minute..... **P.A.M.**

21. I hereby certify that I attended the deceased from..... **May 1** 19**45** to..... **October 12** 19**48**;  
that I last saw him alive on..... **October 12** 19**48**;  
and that death occurred on the date and hour stated above.

Immediate cause of death..... **Pulmonary Tuberculosis 6 mosx.**

Due to.....

Due to.....

Other conditions..... **13 4**  
(Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy..... **Yes**

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)

3. Signature..... **Paul T. Hartman** (M. D. or other)

Address..... **5400 Arsenal** Date signed..... **10/13/48**

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

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

*W. H. Van Matre*

Licensed Embalmer No.

*2825*

P. O. Address

*4840 Lafayette*

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.