

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

FILED OCT 23 1948
Registration District No. **318**

Primary Registration District No. **1003**

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 **4323 Tyrolean**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether **Life**)

In this community.....
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County..... **0-00**

(c) City or town **St Louis**
(If outside city or town limits, write "RURAL") **17**

(d) Street No. **4323 Tyrolean**
(If rural, give location) **9**

(e) Citizen of foreign country?..... (Yes or No) **0**
If yes, name country.....

3. (a) PRINT FULL NAME **Catherine C Beckerle**

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex **F** / 5. Color or race **W**

6. (a) Single, widowed, married, divorced..... **M** /

6. (b) Name of husband or wife **Henry**

6. (c) Age of husband or wife if alive..... **64** years

7. Birth date of deceased **July 23 1883**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **14**
year **1948** hour **2** minute **20** P.M.

21. I hereby certify that I attended the deceased from **January 28**
1948 to **October 14** 19 **48**
that I last saw her alive on **October 14** 19 **48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Uraemia** **3 days**
Chronic myocarditis **2 yrs**
Chronic nephritis **2 yrs**

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.

8. AGE: Years **65** Months **2** Days **21** If less than one day
hr. min.

9. Birthplace **St Louis Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business.....

MOTHER FATHER

12. Name **Jacob A Necker**

13. Birthplace **St Louis Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Storch**

15. Birthplace **St Louis Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Henry Beckerle**
(b) Address **4323 Tyrolean**

17. (a) **Burial** (b) Date thereof **10/18/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Pauls Church**

18. (a) Signature of funeral director **J. B. L... ..**
(b) Address **7127 St. Louis**

19. (a) **OCT 16 1948** (b) **J. B. L... ..**
(Date received local registrar) (Registrar's signature)

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?..... **0**

(e) While at work?..... (Specify type of place)

(f) Means of injury.....

23. Signature **Elmer Simpson** (M.D. or other) **M.D.**
Address **3739 Gravois** Date signed **10/15/48**

rule

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. G. Peterson

Licensed Embalmer No. 3767

P.O. Address 7027 Gravoie

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.

Registration District No. 318 Primary Registration District No. 1003

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(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: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Catherine C. Beckel

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased July 23 (Month) (Day) (Year)

8. AGE: Years 65 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-16-48 (b) J. B. Rabster (Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

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? _____ (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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 20 1948

S-33913