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FILED MAY 5 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14859

State File No. ....

3850

BIRTH NO. 110832 REG. DIST. NO. 318 PRIMARY REG. DIST. 1003 Registrar's No. ....

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		e. STREET ADDRESS (If rural, give location) 2253 Missouri	

3. NAME OF DECEASED (Type or Print) a. (First) ANNA b. (Middle) MARIE c. (Last) BEYER			4. DATE OF DEATH (Month) (Day) (Year) April 26th, 1950		
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5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 4, 1903	9. AGE (In years last birthday) 46	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Carpenter, Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Julia Sparks	14. NAME OF HUSBAND OR WIFE Wm. F. Beyer
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Wm. F. Beyer	ADDRESS 2253 Missouri, St. Louis, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Meningitis (pneumococcal)		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Bilateral Otitis Media DUE TO (c) Hypertension, obesity II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 2912 (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 4/24/50, 19, to 4/26/50, 19, that I last saw the deceased alive on 4/26/50, 19, and that death occurred at 3:30am m., from the causes and on the date stated above.

23a. SIGNATURE Arnold J. Schuman, M.D.	(Degree or title)	23b. ADDRESS 1515 Lafayette Ave.	23c. DATE SIGNED 4/26/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE April 28, 1950	24c. NAME OF CEMETERY OR CREMATORY National Cemetery	24d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.
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DATE REC'D BY LOCAL REG. APR 26 1950	REGISTRAR'S SIGNATURE J. B. Pasater	25. FUNERAL DIRECTOR'S SIGNATURE C. Hoffmeister	ADDRESS U. & L. Co. 7814 S. Broadway
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Leino E. Heffner*

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broad

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.