

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9890

State File No. ....

FILED MAR 19 1954

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 2239

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		c. LENGTH OF STAY (In this place) life		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mes. 5823 Cabanne Ave.		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or Print)		a. (First) BELMONT		b. (Middle) WARREN	
		c. (Last) BEINKE		4. DATE OF DEATH (Month) (Day) (Year) March 10, 1954	
5. SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Nov. 9, 1889	9. AGE (In years last birthday) 64
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman		10b. KIND OF BUSINESS OR INDUSTRY Burroughs Glass		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Henry Beinke		13b. MOTHER'S MAIDEN NAME Mary Michael	
14. NAME OF HUSBAND OR WIFE Gladys Beinke		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW I		16. SOCIAL SECURITY NO. 494-07-6381	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Gladys Beinke		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.		19. ADDRESS 5823 Cabanne	
18. CAUSE OF DEATH		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Prostate</u>		ANTECEDENT CAUSES			6 mos.
DUE TO (b) <u>Hemorrhage from Prostate</u>		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			3 wks.
DUE TO (c) <u>Melanoma to carcinoma</u>		II. OTHER SIGNIFICANT CONDITIONS			2 mos.
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"/>
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) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 177x	
22. I hereby certify that I attended the deceased from <u>12-11</u> , <u>1952</u> , to <u>3-9</u> , <u>1954</u> , that I last saw the deceased alive on <u>3-</u> , <u>1954</u> , and that death occurred at <u>105</u> A. M., from the causes and on the date stated above.					
23a. SIGNATURE <u>Jamie D. Kay</u>		23b. ADDRESS <u>720 Hammond</u>		23c. DATE SIGNED <u>3-10-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE <u>3/11/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>	
				24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>	
DATE REC'D BY LOCAL REG. MAR 10 1954		REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mc Alexander &amp; Sons</u>	
				ADDRESS <u>6175 Delmar</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING 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.....  
Signature of Student Embalmer

Signed *Jos. E. McCulloch*

Licensed Embalmer No. *246*

P. O. Address *6145 Dell*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.