

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38541**
Registrar's No. **10030**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 10030	
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 town) St. Louis		c. LENGTH OF STAY (In this place) 51 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2079 10	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4919 Natural Bridge Blvd.				d. STREET ADDRESS (If rural, give location) 4919 Natural Bridge Blvd.			
3. NAME OF DECEASED (Type or Print) a. (First) JOSEPH		b. (Middle) FERRY		c. (Last) BEALS		4. DATE OF DEATH (Month) (Day) (Year) Nov. 4, 1954.	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced		8. DATE OF BIRTH July 11, 1883.	
9. AGE (In years last birthday) 71		10. KIND OF BUSINESS OR INDUSTRY Oil		11. BIRTHPLACE (City and State or Foreign Country) Friendsville, Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Oil		11. BIRTHPLACE (City and State or Foreign Country) Friendsville, Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME James Franklin Beals		13b. MOTHER'S MAIDEN NAME Sarah Adeline Jones		14. NAME OF HUSBAND OR WIFE Ella Beals			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Carl Bruckmann, 4919 Natural Bridge Bl.			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CA of Prostate with generalized metastatic carcinomatosis. ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND 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 July, 1949 , to November, 1954 , that I last saw the deceased alive on _____, 19____, and that death occurred at 2:00A. m. , from the causes and on the date stated above.							
23a. SIGNATURE Carl Bruckmann M.D.		23b. ADDRESS 607 N. Grand Blvd St. Louis 3, Mo.		23c. DATE SIGNED 11/4/54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE 11/6/54.		24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
DATE REC'D BY LOCAL REG. NOV 5 1954		REGISTRAR'S SIGNATURE g Earl Smith md		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Calvin F. Feutz, 4828 Natural Bridge Blvd.			

(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 *John A. Wilson*
Licensed Embalmer No. *4186*

P. O. Address *St. Louis Mo.*

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.