

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41819

FILED JAN 6 1956

State File No. 11226

BIRTH NO.		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	Registrar's No.
1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jefferson		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN Festus	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		e. STREET ADDRESS (If rural, give location) 0507		
3. NAME OF DECEASED (Type or Print) a. (First) Lester		b. (Middle) Daily	c. (Last) Bequette	4. DATE OF DEATH (Month) (Day) (Year) 12 19 55
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 3-8-98	9. AGE (In years last birthday) 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass Worker		10b. KIND OF BUSINESS OR INDUSTRY P.P. Glass Co	11. BIRTHPLACE (City and State or Foreign Country) Old Mines, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Simeon Bequette		13b. MOTHER'S MAIDEN NAME Roselia Callman	14. NAME OF HUSBAND OR WIFE UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Earl Bequette ADDRESS Festus Missouri	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Infection of Rt. Int. Capsule of Brain ANTECEDENT CAUSES Morbid 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. Cerebral Atrophy		INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 332 x J		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 12/17/55 to 12/19/55 , that I last saw the deceased alive on 12/19/55 and that death occurred at 4 A m., from the causes and on the date stated above.				
23a. SIGNATURE Charles Knowlton		23b. ADDRESS 16 Plaza Hampton Village		23c. DATE SIGNED 12/20/55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-22-55	24c. NAME OF CEMETERY OR CREMATORY Old Mines, Missouri	24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. DEC 22 1955	REGISTRAR'S SIGNATURE Paul Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Politte Funeral Home, Crystal City, Mo ADDRESS		

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.....
Signature of Student Embalmer

Signed.....


Licensed Embalmer No.....

P. O. Address.....

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.