

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022676

STATE FILE NUMBER 6074

FILED JUL 7 1959

Registration District No. Primary Registration District No. Registrar's No.

300
-57

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1024a Theobald		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 1024a Theobald
3. NAME OF DECEASED (Type or print) First MIDDLE Last HELEN A. BECKMANN			4. DATE OF DEATH Month Day Year June 25 1959
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY home	9. AGE (In years) 80 (birth day)
13a. FATHER'S NAME Benjamin Humphries		13b. MOTHER'S MAIDEN NAME Mary Galvin	12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 490 36 8579	17. INFORMANT Address Robert Beckmann 1024a Theobald Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vasculer - Renal disease - Hypertension			INTERVAL BETWEEN ONSET AND DEATH 10-12 hrs
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. DUE TO (b) Arterio Sclerotic Cardio Vasculer disease			" "
DUE TO (c) 442x			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Partial Blindness due to Cataracts - Inanition of Age			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 1950 to June 25 1959 and last saw her alive on June 25 1959 Death occurred at 9 P.M. 1:10 m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Dr. C. N. Lindeman M.A.		22b. ADDRESS 4126 Shreve Ave	22c. DATE SIGNED 6/26/59
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 6/29/59	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Mo.
24. FUNERAL DIRECTOR Buchholz Mort. 5967 W. Florissant Av.		25. DATE RECD. BY LOCAL REG. JUN 27 '59	26. REGISTRAR'S SIGNATURE Karl Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

NOV 10 1959

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

Gustav W. Duteil

Licensed Embalmer No. *4329*
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.