

# MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042761

FILED VS DEC 3 1959

STATE FILE NUMBER

RECEIVED

Registration District No. 317 Primary Registration District No. 521 Registrar's No. 3081

<b>1. PLACE OF DEATH</b> a. COUNTY <u>St. Louis</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>University City</u>		Length of stay in 1b <u>70 yrs.</u>		c. CITY OR TOWN <u>University City</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>7068 Maryland</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>7068 Maryland</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Iida Elizabeth Beyer</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>November 19, 1959</u>				
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>5/30/1883</u>	<b>9. AGE</b> (last birthday) <u>76</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>At Home</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>At Home</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>St. Charles, Mo.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.</u>	
<b>13a. FATHER'S NAME</b> <u>Charles Kern</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>U.K. Dobler</u>			<b>14. NAME OF HUSBAND OR WIFE</b> <u>Albert E. (Deceased)</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> Address <u>Mrs. John W. Hoffman 7068 Maryland</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Art sclerotic cerebral cordis rose disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>27 hr.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour a.m. p.m.		Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)			<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY		STATE	
<b>21. I attended the deceased from</b> <u>8-12-59</u> to <u>11-19-59</u> and last saw her/him alive on <u>11-14-59</u> Death occurred at <u>8:45 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
<b>22a. SIGNATURE</b> (Deceased or informant) <u>Waeyee O. Burke</u>				<b>22b. ADDRESS</b> <u>100 No. Euclid</u>			<b>22c. DATE SIGNED</b> <u>11-20-59</u>	
<b>23a. BURIAL CREMATION, REMOVAL</b>		<b>23b. DATE</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b>			<b>23d. LOCATION</b> (City, town, or county) (State)		
<u>Nov. 21, 1959</u>		<u>Resurrection Cemetery</u>			<u>St. Louis Co. Mo.</u>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Arthur J. Donnelly 2810 Lindell Blvd.</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>11-20-59</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>John C. Murphy M.D.</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Francis Hillion

Licensed Embalmer No. 356

P. O. Address 3840 Lincoln

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.