

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 5 1960 317

60-004491

Registration District No. _____ Primary Registration District No. 590 Registrar's No. 77

STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>St. Louis</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wellston</u>		a. STATE <u>Mo.</u>		b. COUNTY <u>St. Louis</u>	
Length of stay in 1b <u>47 Yrs.</u>		c. CITY OR TOWN <u>Wellston</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1536 Wellston Ave.</u>				d. STREET ADDRESS (If outside, give location) <u>1536 Wellston Ave.</u>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>Louis</u>		Middle <u>G.</u>		Last <u>Bewig</u>		Month <u>1</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/21/81</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>George W. Bewig</u>			13b. MOTHER'S MAIDEN NAME <u>Regina Ackerman</u>			14. NAME OF HUSBAND OR WIFE <u>Bena Bewig</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>489-18-2323</u>		17. INFORMANT Address <u>Mrs. Bena Bewig, 1536 Wellston</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Coronary occlusion.</u>						<u>12 hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>metastatic ca of lung</u>						<u>6 months</u>	
DUE TO (c) <u>ca of bladder</u>						<u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>181.0</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 _____ a.m. _____ p.m. Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT WORK <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 <u>Jan 7 - 50</u> to <u>Jan 8 60</u> and last saw <u>him</u> alive on <u>Jan 8 - 60</u> Death occurred at <u>9:25 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>E E King</u> (Degree or title) <u>M.D.</u>				22b. ADDRESS <u>2114 E Grand</u>			22c. DATE SIGNED <u>8 Jan 60.</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1/11/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Keystone Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Jacob, Ill.</u>		(State)	
24. FUNERAL DIRECTOR ADDRESS <u>Drehmann-Harral, 1905 Union Blvd.</u>			25. DATE RECD. BY LOCAL REG. <u>1-10-60</u>	26. REGISTRAR'S SIGNATURE <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 _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Walter Thompson

Licensed Embalmer No. 4237

P. O. Address St. Louis

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.