

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-021224
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Primary Registration District No. 500 Registrar's No. 1619

FILED JUN 11 1962

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
Rev. 4/59		
14019	INSTEAD OF	DOCUMENT
2400X		
3	BY AFFIDAVIT OF	SHOULD READ
4 0		
5 0	ITEM NO.	BY AFFIDAVIT OF
6		
7 0	SHOULD READ	DOCUMENT
8 2		
9 154X	ITEM NO.	BY AFFIDAVIT OF
10		
11	SHOULD READ	DOCUMENT
12 136-0		
13	ITEM NO.	BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Creve Coeur		Length of stay in 1b 3 wks	c. CITY OR TOWN Overland Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Green Valley Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2224 Wengler Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle Becker Last Becker		4. DATE OF DEATH Month May Day 28 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/24/1880
9. AGE (last birthday) 81		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY St Louis Co Mo	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Ferdinand Becker		13b. MOTHER'S MAIDEN NAME Magdeline Siegler	
14. NAME OF HUSBAND OR WIFE Pauline Abram		Address 9105 Goodale Overland Mo	
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. None	
17. INFORMANT Pauline Abram		Address 9105 Goodale Overland Mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rectum			INTERVAL BETWEEN ONSET AND DEATH 2 mo?
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): Arteriosclerotic Heart Disease		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 May 2, 1962 to May 28 and last saw him alive on May 22, 1962 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert S. Angles M.D. (Degree or title)		22b. ADDRESS 11745 Olive St Mo	22c. DATE SIGNED 5/29/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5/30/1962	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St Louis Mo
24. FUNERAL DIRECTOR Ortmann F Home ADDRESS 9222 Lackland Overland Mo		25. DATE RECD. BY LOCAL REG. 5-30-62	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

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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.