

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

1784-63-008299
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____

FILED FEB 28 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Length of stay in 1b 3 Weeks		Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hamilton Conv. Medical Center		d. STREET ADDRESS (If outside, give location) 4421 Gibson	
Reside on Farm <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle D. Last BEARD			4. DATE OF DEATH Month February Day 16 Year 1963
5. SEX Male	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 5/6/98
9. AGE (last birthday) 64		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Blacksmith	11. BIRTHPLACE (City and state or country) Bismark, Missouri
12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Joseph Newton Beard		13b. MOTHER'S MAIDEN NAME Rebecca E. Watson	
14. NAME OF HUSBAND OR WIFE -----			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War 1		16. SOCIAL SECURITY NO. _____	
17. INFORMANT James D. Beard		Address South Plainfield, N.J.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno Carcinoma Lung, St. Metastatic? (Primary site not determined) 165x			INTERVAL BETWEEN ONSET AND DEATH 6 wks
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 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 checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	20f. CITY, TOWN, OR LOCATION	COUNTY _____ STATE _____
21. I attended the deceased from 5 Jan. 1963 to 17 Feb. 1963 and last saw him alive on 9 Feb. 1963 Death occurred at 11:50 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE John W. Magness M.D. (Degree or title)		22b. ADDRESS 6651 North University City Mo	22c. DATE SIGNED 18 Feb 1963
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/19/63	23c. NAME OF CEMETERY OR CREMATORY St. Matthew Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Missouri
24. FUNERAL DIRECTOR White-Mullen Mort. Ferguson Mo.		25. DATE RECD. BY LOCAL REG. FEB 18 1963	26. REGISTRAR'S SIGNATURE Loed Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

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ITEM NO. SHOULD READ

93, C.B. 18

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 Reinhold K. Lehmann

Licensed Embalmer No. 3395

P. O. Address St Louis 35 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.