

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**-63-013015**

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3250**

DO NOT WRITE ON THIS STUB

AMENDED

**FILED MAR 28 1963**

VS 300 Rev. 4/59	AMENDED	DAVE	AMENDED	INSTEAD OF	DOCUMENT	BY AFFIDAVIT OF	MEDICAL CERTIFICATION	SHOULD READ	ITEM NO.	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
1										
2 <i>20</i>										
3										
4 <i>1</i>										
5 <i>2</i>										
6										
7 <i>0</i>										
8 <i>2</i>										
9										
10										
11										
12 <i>86-0</i>										
13										
<i>86</i>										

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>5 Months</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Hamilton Medical Center</b>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>956 Hamilton Ave.</b>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>1963</b>	
3. NAME OF DECEASED (Type or print) <b>MAGDALENA BECKERLE</b>		First Middle Last	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-23-1876</b>
9. AGE (last birthday) <b>86</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>13</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	
11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John Hilger</b>		13b. MOTHER'S MAIDEN NAME <b>Pauline Trapp</b>	
14. NAME OF HUSBAND OR WIFE <b>John Beckerle</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Johnson 6734 Clayton Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Emphysema of Leg</b> <b>General Arteriosclerosis</b> <b>4501</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>5 years</b>	
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) <b>Arteriosclerotic Heart Disease</b>	
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		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 <b></b> Month, Day, Year <b></b> a.m. p.m.		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 <b>1951</b> to <b>March 18, 1963</b> and last saw her alive on <b>March 15, 1963</b> Death occurred at <b>10:25 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>Walter W. Davis, M.D.</b>	
22b. ADDRESS <b>539 N. Grand Ave</b>		22c. DATE SIGNED <b>3/19/63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Mar. 21, 1963</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sts. Peter &amp; Paul Cem.</b>		23d. LOCATION (City, town, or county) STATE <b>St. Louis Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>A.H. Bocklage 6536 Clayton Rd.</b>		25. DATE RECD. BY LOCAL REG. <b>MAR 20 1963</b>	
26. REGISTRAR'S SIGNATURE <b>Paul Smith, M.D.</b>			

USE BLACK INK OR TYPEWRITER RIBBON

**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 Robert M. Murray

Licensed Embalmer No. 3749

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.