

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-013020

DO NOT WRITE ON THIS STUB
 AMENDED

Registration District No. **318** Primary Registration District No. _____ Registrar's No. **2816**

STATE FILE NUMBER

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED MAR 20 1963			
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 15 Years	c. CITY OR TOWN St. Louis
c. FULL NAME OF HOSPITAL OR INSTITUTION (If in hospital, give location) St. Louis Hosp.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 112 S. 4th St.
3. NAME OF DECEASED (Type or print) J. Beiter		Middle Last	4. DATE OF DEATH Month Day Year Feb. 27, 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 1-19-1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 65
13a. FATHER'S NAME Jeff David Beiter		11. BIRTHPLACE (City and state or country) Evansville, Ill.	
13b. MOTHER'S MAIDEN NAME Albertha Elliff		12. CITIZEN OF WHAT COUNTRY USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Address Alfred Beiter - E. St. Louis, Ill.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion. Coronary Sclerosis. DUE TO (b) 420.1 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>
20c. TIME OF INJURY Hour Month, Day, Year. p.m.			20e. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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 _____ to _____ and last saw him/her alive on _____ Death occurred at 4:50 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dr. M. J. Quinn Deputy		22b. ADDRESS 1300 Carl	22c. DATE SIGNED 3-11-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Mar 11, 1963	23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel
24. FUNERAL DIRECTOR Burke Funeral Home		25. DATE RECD. BY LOCAL REG. MAR 11 1963	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
23d. LOCATION (City, town, or county) Belleville, Illinois			

checked up at coroners
 1/11/1963
 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 Chas M. Burke

Licensed Embalmer No. 2421

P. O. Address E. St. Louis, Ill.

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.