

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-034290

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2546 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 23 1963

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PENN NURSING</u>		d. STREET ADDRESS (If outside, give location) <u>3336 SALENA</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM H BECKEMEYER</u>		4. DATE OF DEATH Month Day Year <u>Aug. 9, 1963</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 28 1875 87</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED WAREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ELDER MFG.</u>	11. BIRTHPLACE (City and state or country) <u>CARLYLE ILL.</u>
13a. FATHER'S NAME <u>WILLIAM BECKEMEYER</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>ELIZABETH (DEC)</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>417</u>	
17. INFORMANT <u>WILLIAM H BECKEMEYER 3336 SALENA</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Renal Vasculodema</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio sclerosis</u> DUE TO (c) <u>Senility</u>			INTERVAL BETWEEN ONSET AND DEATH
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 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>7-9-63</u> to <u>8-9-63</u> and last saw him alive on <u>8-6-63</u> Death occurred at <u>11</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W. E. Morris M.D.</u> (Degree or title)		22b. ADDRESS <u>4110 W Flannan Ave</u>	22c. DATE SIGNED <u>8-9-63</u>
23a. BURIAL CREMATION, REINTERMENT (Specify)	23b. DATE <u>Aug. 12, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET BURIAL PARK</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co Mo</u>
24. FUNERAL DIRECTOR <u>Thomas Kutes</u> ADDRESS <u>2906 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>8-12-63</u>	26. REGISTRAR'S SIGNATURE <u>John G. Murphy M.D.</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

VS 300 Rev. 4/59

1 4000

2 22

3

4 0

5 2

6

7 1

8 2

9 442X

10

11 86-0

13

USE BLACK INK OR TYPEWRITER RIBBON

86

To: Mr. Harvey D. Davis
4710 W. 9th Street
St. Louis, Mo.

TE 3-8824

Will G. Davis

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 Will G. Davis

Licensed Embalmer No. 4772

P.O. Address 2906 Graves

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.