

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-045206**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12108** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1

2

3

4

5

6

7

8

9

10

11

12

13

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

BY AFFIDAVIT OF

**FILED DEC 12 1963**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jefferson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>3 1/2 Weeks</b>	c. CITY OR TOWN <b>Arnold Missouri</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Missouri Baptist Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>Route #3 Box 801</b> <b>Arnold Missouri</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Anna (Ann)</b> Middle <b>Beckring</b> Last <b>Beckring</b>			4. DATE OF DEATH Month <b>December</b> Day <b>5</b> Year <b>1963</b>			
--	--	--	---	--	--	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-15-1915</b>	9. AGE (last birthday) <b>48 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR. Days	Hours	Min.
-------------------------	----------------------------------	---	--------------------------------------	--	---------------------------	-------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Punch Press Operator</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Schlueter Can Co.</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
--	---	---	---

13a. FATHER'S NAME <b>August Meyer</b>	13b. MOTHER'S MAIDEN NAME <b>Anna Stark</b>	14. NAME OF HUSBAND OR WIFE <b>Fred Beckring</b>
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of)	NO	17. INFORMANT <b>Mr. Fred Beckring</b> <b>Route #3 Box 801 Arnold Missouri</b>
---	----	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA LUNG &amp; BRAIN</b> <b>PRIMARY SITE UNDET.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 Months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) DUE TO (c)		<b>199.2</b>

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 checked="" 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 <b>2:30</b> <b>5 Nov 1963</b> and last saw her/him alive on <b>5 DEC. 1963</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE (Degree or title) <b>Rose A Meyer MD</b>	22b. ADDRESS <b>567 No 5th St. Louis 30</b>	22c. DATE SIGNED <b>12/7/63</b>
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12-9-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County Missouri</b>
---	-------------------------------	---	---

24. FUNERAL DIRECTOR <b>Math Hermann &amp; Son, Inc. 2161 E. Fair St. Louis Missouri 63107</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 9 1963</b>	26. REGISTRAR'S SIGNATURE <b>Loard Smith, M.D.</b>
---	---	---

USE BLACK INK OR TYPEWRITER RIBBON

**68**

**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 *William B. Bacon*

Licensed Embalmer No. 5146

P. O. Address *1725 ... 1110*

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.