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ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38422

Registrar's No. 2724

FILED DEC 8 1945

Registration District No. 1

Primary Registration District No. 4467

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County ST. Louis
(b) City or town Valley Park Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County ST. Louis 9/6
(c) City or town Valley Park 1/6
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) _____
(e) Citizen of foreign country? _____ (Yes or No) _____
If yes, name country _____

3. (a) PRINT FULL NAME Emily Inaba Bequette

3. (b) If veteran, name war _____ 3. Social Security No. _____

4. Sex FEMALE 5. Color or race White 6. (a) Single, widowed, married, divorced, MARRIED

6. (b) Name of husband or wife Felix C. Bequette 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased April 25 1875
(Month) (Day) (Year)

8. AGE: Years 70 Months 7 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace ST. FRANCIS Co Mo A
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

12. Name FRANK BYINGTON

13. Birthplace UNKNOWN U.S.A. 1
(City, town, or county) (State or foreign country)

14. Maiden name MELISSA MACKLEY

15. Birthplace ST. FRANCIS Co Mo A
(City, town, or county) (State or foreign country)

16. (a) Informant PAUL F. BEQUETTE
(b) Address 5754 Theodora

17. (a) REMOVAL (b) Date thereof DEC 3, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bonne Terre Mo

18. (a) Signature of funeral director Calvin E. Santa Federal Home
(b) Address 71428 Natural Bridge Blvd.
19. (a) 12-3-45 (b) C. G. M. Jansen M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 30
year 1945 hour 8 minute 15 A. M.

21. I hereby certify that I attended the deceased from 11/29/45, 19____ to 11/30/45, 19____;
that I last saw her alive on 11/29/45, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Internal hemorrhage

Due to Hypertension

Due to Smility 112

Other conditions Chronic bronchitis
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature Clara M. Schurr (M. D. or other) MD
Address Valley Park Mo Date signed 11/30/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

EMILY ISABELLE

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Sam W. Szymore*
Licensed Embalmer No..... *4343*
P. O. Address..... *7415 Zephyr Pl Maplewood 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 this body is not embalmed, fact should be so stated above.