

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

16395

1. PLACE OF DEATH
County GREENE Registration District No. 318
Township SPRINGFIELD Primary Registration District No. 200
City 1609 E. BLAINE St. _____ Ward _____

2. FULL NAME SHIRLEY JEAN BEASLEY
(a) Residence, No. 1609 E. BLAINE St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) SINGLE

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) APRIL 24-1934

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 0 24

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. INFANT

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. IN HOME

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

13. NAME CHAS. BEASLEY 8

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ILL.

15. MAIDEN NAME LAVIRA BRUST.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) NEB.

17. INFORMANT LAURA BEASLEY
(ADDRESS) SPRINGFIELD MO

18. BURIAL, CREMATION, OR REMOVAL
PLACE Highwood DATE MAY 19 1934

19. UNDERTAKER J.W. KLIN GAYNER & CO.
(ADDRESS) SPRINGFIELD MO.

20. FILED 5-18 1934

1 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-18-1934

22. I HEREBY CERTIFY, That I attended deceased from 5-16-1934 to 5-18-1934

I last saw her alive on 5-16-1934. Death is said to have occurred on the date stated above, at 12 noon

The principal cause of death and related causes of importance were as follows:

Bronchial pneumonia Date of onset 5-15-34

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) C. E. Zeller, M. D.

(Address) Springfield Mo.

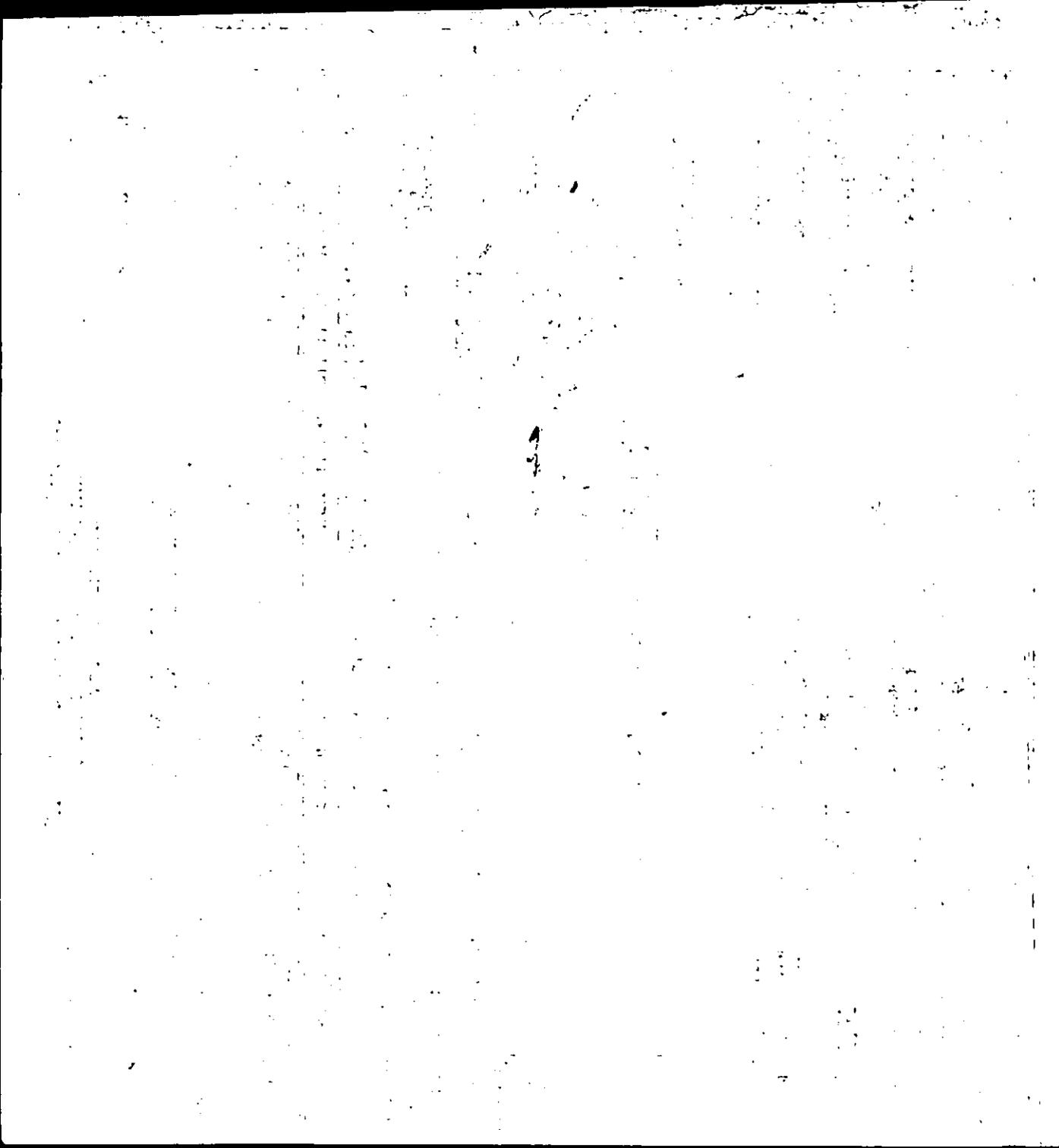
3. Every item of information should be carefully supplied. - No. 10-10-34. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

3.
05.10.34

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[Handwritten signatures and notes at the bottom of the page]



#2 *Greene*

DEPARTMENT OF COMMERCE

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

BUREAU OF THE CENSUS *16395 -*

WASHINGTON

224

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Shirley Jean Beasley*
Who died at _____ on *5-18-1934*
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: _____ Years _____ Months _____ Days _____
Sex *7* Color or race *W* Single, ~~married~~, ~~widowed~~ or ~~divorced~~.

Date of birth _____ Age: Years _____ Months _____ Days *24*

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year *1934*

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: *Bronchial Pneumonia - Primary*

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar *Shurvellian*

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. *318*

Very truly yours,

Primary Reg. Dist. No. *2001*

E. T. McGaugh, M.D.
Special Agent. *mt.*

S-16395

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