DEC 15 1934

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

39205

V. S. No. 2.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
County Henry
Township
City Clinton Mo. No. St. Ward)

Registration District No. 347
Primary Registration District No. 3018
File No.
Registered No. 59

2. FULL NAME Margaret Milanda Beckner
(a) Residence. No. 215 W Benton St. Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: James Beckner

DATE OF BIRTH (MONTH, DAY AND YEAR): Dec 2 1875

AGE: YEARS 58 | MONTHS 11 | DAYS 11 | If LESS than 1 day, ...hrs. or ......min.

OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Life
(c) Name of employer

BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): North Missouri

10. NAME OF FATHER: Wm King
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Tenn ~~Kentucky~~
12. MAIDEN NAME OF MOTHER: Do not Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Don't Know

INFORMANT: Minnie Briggs
(Address) Clinton Mo

FILED 12-6 1934 J R Hampton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov 13 1934

17. I HEREBY CERTIFY, That I attended deceased from Sept 9/1934, 19...., to Nov 13 1934
that I last saw her alive on Nov 13, 1934 and that death occurred, on the date stated above, at 4:35 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer of axillary glands secondary to cancerous disease on hand
(duration) yrs. 3 mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Dr. Woltzen, M. D.
, 19 (Address) Clinton Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Fields Creek
DATE OF BURIAL: 11-15 1934

20. UNDERTAKER: Fred Wilkinson
ADDRESS: Clinton

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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MISSOURI STATE BOARD ... TH

BUREAU OF VITAL STA...

CERTIFICATE OF DEA...

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No..... ..... St. ..... We...

2. FULL NAME.....

(a) Residence. No..... 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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT.....
(Address)

15.
FILED....., 19.....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1...

17.
I HEREBY CERTIFY, That I attended deceased from.....
....., 19....., to....., 19...
that I last saw h..... alive on....., 19....., and
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) .....yrs.....mos.....

CONTRIBUTORY
(SECONDARY)
..... (duration) .....yrs.....mos.....

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed)....., M...
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 1...
20. UNDERTAKER	ADDRESS