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.

REC'D MAR 20 1939

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

6876
Do not use this space.

1. PLACE OF DEATH
(a) County Jasper — Registration District No. 415
(b) Township Sarcoxie — Primary Registration District No. 4247 — Registered No.
(c) City Reeds — (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 504 Fanny May Beam
(a) Residence, No. ..... St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: James Beam
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Aug. 8, 1858
7. AGE: YEARS 80 — MONTHS 5 — DAYS 26 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Housekeeper
9. Industry or business in which work was done, as saw mill, bank, etc.
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): Climax, Michigan

FATHER
13. NAME: Robert Elwell
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): New York

MOTHER
15. MAIDEN NAME: Dollie Powers
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown, Unknown

17. INFORMANT (ADDRESS): Mrs. Maud Lewis, Carthage, Mo.
18. BURIAL, CREMATION, OR REMOVAL — PLACE: Reeds Cem. — DATE: Feb. 5, 1939
19. FUNERAL DIRECTOR (ADDRESS): Knell Mortuary, Carthage, Mo.
20. FILED: 2/5, 1939 — Geo L Bragdon, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Feb. 4, 1939

22. I HEREBY CERTIFY, That I attended deceased from Jany 29th, 1939, to Feby 3rd, 1939. I last saw her alive on Jany 31st, 1939. Death is said to have occurred on the date stated above, at 3:05 a.m.
The principal cause of death and related causes of importance were as follows:

Broncho Pneumonia, Influenza — Date of onset 1/29-39

93C

Other contributory causes of importance: Chronic Myocardosis

Name of operation — Date of —
What test confirmed diagnosis? Lab. 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? No
If so, specify
(Signed) Geo. L. Bragdon, M. D.
375 (Address) Reeds Mo

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 6-39-663
Date Filed MAR 16 1939

STATEMENT BY LICENSED EMBALMER

I, Emm R Stuell, Licensed Embalmer No. 391

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

L. E.

No. or by , Registered Apprentice No.

working under my personal supervision.

Signed Emm R Stuell

Licensed Embalmer No. 391

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)