

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.

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

7623
Do not use this space.

1. PLACE OF DEATH
(a) County Demarcat Registration District No. 641
(b) Township of Primary Registration District No. 4388 Registered No. 1
(c) City Carthage (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 _____ if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Arthur A. Beckner
(a) Residence, No. _____ St. _____
(Usual place of abode, if no street address, write county or city) (If non-resident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 18, 1888
7. AGE YEARS 5-0 MONTHS 6 DAYS 14 If LESS than 1 day, hrs. min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Sawyer
9. Industry or business in which work was done, as saw mill, bank, etc. Mon. High. Co.
10. Date deceased last worked at this occupation (month and year) _____ Total time (years) spent in this occupation _____
11. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cape Girardeau, Mo.
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cape Girardeau, Mo.
13. NAME Burgess S. Beckner
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Williamson Co. Ill.
15. MAIDEN NAME Elizabeth Volmer
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scott Co. Mo.
17. INFORMANT Roy Beckner
(ADDRESS) Cape Girardeau, Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Cape Girardeau, DATE Jan. 2, 1940
19. FUNERAL DIRECTOR (NAME) Brinkley - Howell Firm
(ADDRESS) Cape Girardeau, Mo.
20. FILED Jan. 2, 1940 Ada Martin
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 2, 1940
22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.
I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____.
The principal cause of death and related causes of importance were as follows:
Definite cause of death not determined
Possibly Coronary Occlusion
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) Fred L. Ogilvie, Health Officer
(Address) Carthage, Mo.

35-2-40

S(2)-3282

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

3282
7623
State File No. _____
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
Registration District No. 657

Primary Registration District No. 4388

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

1. PLACE OF DEATH:
(a) County Demarest
(b) City or town Canthersville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 Missouri (b) County Lape Co.
(c) City or town Lape Girardeau
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRIMARY FULL NAME Arthur A. Beckner
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

20. DATE OF DEATH: Month 1 day 2
year 1940 hour _____ minute _____ M.

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____
6. (c) Age of husband, or wife, if alive _____ years
7. Birth date of deceased _____
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

8. AGE: Years 50 Months 6 Days 14
If less than one day _____ min.

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (c) Signature of funeral director _____

(b) Address _____

19. (a) April 13, 1940 (b) Ada Martin
(Date received local registrar) (Registrar's signature)

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? _____

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

23. Signature Fred L. Ogilvie (M. D. or other) H-O.

Address Canthersville Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

S(2)-3282