

WHILE FADING BLACK INK—MAKE A PERMANENT RECORD

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.

Registration District No. 200

Primary Registration District No. 555310

Registrar's No. 98

1. PLACE OF DEATH

(a) County Jackson

(b) City or town Prairie (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Jackson County Home for the Aged (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 17 years 3 mo (Specify whether

In this community _____ years, months or days)

3. (a) PRINT FULL NAME Charles Beacham

3. (b) If veteran, name war.

3. (c) Social Security No. W

4. Sex m

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: May 11 1850 (Month) (Day) (Year)

8. AGE: Years 89 Months 11 Days 17 If less than one day hr. _____ min. _____

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

10. Usual occupation laborer

11. Industry or business unknown

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant's own signature J. M. Mullen

(b) Address 70 County Home

17. (a) burial (b) Date thereof 5-7-40 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield

18. (a) Signature of funeral director J. M. Mullen

(b) Address _____

19. (a) 5-2-40 (b) Sarah E. Stone (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson

(c) City or town Little Blue (If outside city or town limits, write "RURAL")

(d) Street No. 26 Home (If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 28 year 1940 hour 9 minute 15 P. M.

21. I hereby certify that I attended the deceased from 4-1, 1940, to 4-28, 1940; that I last saw him alive on 4-26, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death: senile debility Duration _____

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) 162

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? Yes

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

23. Signature J. W. Greene (M. D. certificate) _____
Address Superior Ave Date signed 4/28/40

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

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..... *Wm. H. Ward*

Licensed Embalmer No. *3991*

P. O. Address. *5725 Virginia*

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.