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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

18829

Registration District No. 960 Primary Registration District No. 5623 4273 State File No. _____ Registrar's No. 21

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Dover, Mo.
(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 2
In this community _____
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Ella R. Beverly 164
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Colored
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Grant Beverly
6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased June 2nd 1869
(Month) (Day) (Year)

8. AGE: Years 70; 2 Months 10 Days 10
If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name Amos Davis
18. Birthplace Kentucky
14. Maiden name Anna Jackson
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Ethel Stanford
(b) Address Dover, Mo.

17. (a) Burial (b) Date thereof 4/14/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Dover, Mo.

18. (a) Signature of funeral director W. H. ...
(b) Address Higginsville, Mo.

19. (a) 4/24/40 (b) Tessie Webb
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Lafayette
(c) City or town Dover
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12th day April
year 1940 hour 2-00 minute P M.

21. I hereby certify that I attended the deceased from Jan 11th 1940 to April 12 1940
that I last saw her alive on April 9 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Alzheimer's Disease
Chronic Septicemia
Heart & Coronary Arteriosclerosis
Due to Arteriosclerosis

Other conditions (Include pregnancy within 3 months of death) 131

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following: no.
(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? 413
While at work? _____ (Specify type of place) Mean of injury _____
23. Signature W. H. ... (M. D. or other) _____
Address Brimstone, Mo. Date signed 4/13/40

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

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 6-11-9

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 _____

Forest Riekhof _____, Registered Apprentice No. _____
working under my personal supervision.

Signed Forest Riekhof

Licensed Embalmer No. 3637

P. O. Address Higginsville, Mo.

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

State File No. 18829

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 460

Primary Registration District No. 4273

Registrar's No. 21

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

1. PLACE OF BIRTH:

(a) County Lafayette
(b) City or town Plover
(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)

3. (a) PRINT FULL NAME

Ella R. Beverly

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7

5. Color or race col

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)

8. AGE:

Years 70 Months 10 Days 10

If less than one day _____ hr. _____ min.

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) _____

(Burial, cremation, or removal)

(b) Date thereof _____

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7-6-1940

(Date received local registrar)

(b) T. J. W. Welch

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette

(c) City or town Plover
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 14 day 12
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h_____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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)
(2) Means of injury _____

23. Signature J. C. Wood (M. D. or other) _____

Address Keosauqua _____

SUPPLEMENTARY

S-18829