

FILED JUL 15 1940

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

21167

Do not use this space.

1. PLACE OF DEATH

(a) County Benton Registration District No. 59
(b) Township Williams Primary Registration District No. 5094 Registered No. 14
(c) Cole Camp, Mo. Rt. 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. 2 (f) How long in U. S., if of foreign birth? yrs. mos. ds. 0

2. PRINT FULL NAME

(a) Residence, No. 200 Lake Park St. (If nonresident, give city or town and State)
Cole Camp, Mo. Rt. (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-13-1929

7. AGE YEARS 11 MONTHS 5 DAYS _____ If LESS than 1 day, _____ hrs. _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home
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 life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cole Camp, Mo.

FATHER 13. NAME Jesse Beck
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Milten, Mo.

MOTHER 15. MAIDEN NAME Phancy Jane Jennings
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Union, Mo.

17. INFORMANT (ADDRESS) Jesse Beck, Cole Camp, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Union Cemetery DATE 5-15-1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. J. Eckhart, Cole Camp, Mo.

20. FILED 6-1- 1940 Sue Belover Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-14-1940

22. I HEREBY CERTIFY, That I attended deceased from 5-13-1940 to 5-14-1940

I last saw him alive on 5-14-1940 Death is said to have occurred on the date stated above, at 11 P.M.

The principal cause of death and related causes of importance were as follows:

Perforated appendix Date of onset _____

Other contributory causes of importance: 121

Name of operation none Date of _____

What test confirmed diagnosis autops Was there an autopsy? no

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) J. J. Beck M. D.
63 (Address) Cole Camp, Mo.

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..... *E. L. Eckhoff*.....
Licensed Embalmer No..... *230*.....
P. O. Address..... *Cole Camp, Ill*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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. 21167

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 59

Primary Registration District No. 5094

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Benton
(b) City or town Williams
(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 _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Lafe Beck

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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 12-13-1929
(Month) (Day) (Year)

8. AGE: Years 10 Months 5 Days 1 If less than one year _____ 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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 6-1-40 (b) Sue Selover
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 5 day 14
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 _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

22. If death _____ 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 T. S. Preser (M. D. or other) _____

Address Cole Camp _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

