

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

28904

Registration District No.

460

Primary Registration District No.

4274

Registrar's No.

41

1. PLACE OF DEATH:

(a) County Lafayette
 (b) City or town Higginsville, MO.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution most of her life (Specify whether
 In this community years, months or days)

3. (a) PRINT FULL NAME Annie Spears Beattie 377
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Robert B. Beattie 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb-8th-1860
 (Month) (Day) (Year)

8. AGE: Years 80 Months 6 Days 22 If less than one day _____ hr. _____ min.

9. Birthplace Near order Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Joseph Carter

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

14. Maiden name Ann Spears
 (City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature A. B. Beattie

(b) Address 227 Adams Blvd. Ash Grove, Mo.

17. (a) Burial (b) Date thereof 9-2-1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Higginsville, Mo.

18. (a) Signature of funeral director Dale Meinhager

(b) Address Higginsville, Mo.

19. (a) 9-19-40 (b) W. J. Webb
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette
 (c) City or town Higginsville, Mo.
 (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 August day 30
 year 1940 hour 1 minute _____ M.

21. I hereby certify that I attended the deceased from August 1st, 1940, to Aug 30, 1940
 that I last saw her alive on Aug 30, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory distress secondary to Chronic myocarditis & Hypertension Duration 8-30-40

Due to Hypertension
Arteriosclerosis

Due to _____

Other conditions (Include pregnancy within 3 months of death) 94W

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? 413

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Ernest M. ... (M. D. or other) MD

Address Higginsville, Mo. Date signed 9-1-40

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.

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

Roy J. Wegler

Licensed Embalmer No. *2983*

P. O. Address. *Higginsville*

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.