No. 2
1-10-39
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X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37588

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4185

FILED DEC 1 1940

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City, Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 501 Norton (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 (Specify whether years, months or days) In this community 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City, Mo. (If outside city or town limits write "RURAL")
(d) Street No. 501 Norton (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Ferdinand F. Beard
3. (b) If veteran, name war None
3. (c) Social Security No. None-Retired ~~Before S. S.~~
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ruby Beard
6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased Nov. 9th, 1881 (Month) (Day) (Year)

8. AGE: Years 58 Months 11 Days 23 If less than one day ____ hr. ____ min.

9. Birthplace ____ (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Watch Maker--Retired
11. Industry or business Mace Ryer Co.
MOTHER FATHER
12. Name John Beard
13. Birthplace ____ (City, town, or county) Indiana (State or foreign country)
14. Maiden name Susan Gilbert
15. Birthplace ____ (City, town, or county) Ill (State or foreign country)
16. (a) Informant Mrs. Ruby Beard,
(b) Address 501 Norton, K.C.Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov. 3-40 (Month) (Day) (Year)
(c) Place: burial or cremation Bismark, Mo.
18. (a) Signature of funeral director C.H.Blackman & Son, Inc.
(b) Address 2825 Indep. Blvd. K.C.Mo.
19. (a) 11-3-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 2 year 1940 hour 5 minute 30 A. M.
21. I hereby certify that I attended the deceased from August 1939, 19__, to Nov. 2, 1940, that I last saw him alive on October 27, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Arteriosclerotic heart disease	2 yrs
Coronary sclerosis	2 yrs
Due to	
Due to 95 B 22	
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? (Specify type of place)
While at work? (e) Means of injury 1

23. Signature Joseph E. Welker (M. D. or other) MD
Address 836 Professional Bldg Date signed 11/2/40 Kansas City Mo

(Licensed Embalmer's Statement on Reverse Side)

Dr. Joseph Welker,
Prof. Bldg.

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 wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.