

Registration District No. \_\_\_\_\_

Primary Registration District No. 2000

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

1. PLACE OF DEATH: **GREENE**  
 (a) County **GREENE**  
 (b) City or town **SPRINGFIELD**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: **SPRINGFIELD CITY HOSP.**  
 (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)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Mo.** (b) County **GREENE 39**  
 (c) City or town **SPRINGFIELD 2**  
 (If outside city or town limits, write "RURAL") **6**  
 (d) Street No. **955 PYTHIAN**  
 (If rural, give location) **ju.**  
 (e) Citizen of foreign country? **No.** (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **LAURA BEESLEY**  
 3. (b) If veteran, name war **NONE**  
 3. (c) Social Security No. **NONE**

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **Oct** day **14**  
 year **1942** hour **1** minute **28 A.M.**

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**  
 6. (b) Name of husband or wife **CHARLES BEESLEY** 6. (c) Age of husband or wife if alive **55** years  
 7. Birth date of deceased **July 3-1899**  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **10/13/42** to **10/13/42** 19.42  
 that I last saw her alive on **10/13/42** 19.42  
 and that death occurred on the date and hour stated above.

8. AGE: Years **43** Months **3** Days **11** If less than one day  
 hr. min.

Immediate cause of death **Cerebral Hemorrhage** Duration **36 hrs**

9. Birthplace **Unknown Neb 1**  
 (City, town, or county) (State or foreign country)

Due to \_\_\_\_\_  
 Due to **83a**

10. Usual occupation **House wife In home**

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

12. Name **William H. Brust**

Of autopsy \_\_\_\_\_

13. Birthplace **Unknown Ohio 1**  
 (City, town, or county) (State or foreign country)

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

14. Maiden name **Miss Davis Ill. 1**  
 (City, town, or county) (State or foreign country)

15. Birthplace **Unknown Ill. 1**  
 (City, town, or county) (State or foreign country)

16. (a) Informant **William H. Brust**  
 (b) Address **Springfield, Mo.**

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_

17. (a) **Burial** (b) Date thereof **Oct 16-1942**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(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? \_\_\_\_\_

18. (a) Signature of funeral director **W. W. Ingner & Co**  
 (b) Address **Springfield, Mo.**

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

19. (a) **10-16-42** (b) **S. W. E. Handley**  
 (Date received local registrar) (Registrar's signature)

23. Signature **S. W. E. Handley** (M. D. or other) \_\_\_\_\_  
 Address **Springfield** Date signed **10/14/42**

**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..... *May A. Pholia*

Licensed Embalmer No. *4071*

P. O. Address *Spring Field*

**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, fact should be so stated above.**