

OCT 22 1943

State File No. \_\_\_\_\_

Registration District No. 146

Primary Registration District No. 3026 5568

Registrar's No. 233

1. PLACE OF DEATH: Jackson  
 (a) County Kansas City, Mo. Blue Tship.  
 (b) City or town (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 8805 Lexington  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 40 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Jackson  
 (c) City or town Kansas City, Mo. Blue Tship.  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 8805 Lexington  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Thomas Joshua Beaman  
 3. (b) If veteran, name war No 3. (c) Social Security No. No

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Sept day 13  
 year 1943 hour 8 minute 30 A.M.

4. Sex Male 5. Color or race W  
 6. (a) Single, widowed, married, divorced, Widowed  
 6. (b) Name of husband or wife Amanda Beaman  
 6. (c) Age of husband or wife if alive Deed. years  
 7. Birth date of deceased Jan. 8, 1861  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 15, 1943 to Sept 13, 1943  
 that I last saw him alive on Sept 12, 1943  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death Hypostatic pneumonia

8. AGE: Years 82 Months 8 Days 5  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Multiple-Metastatic carcinoma  
 Due to \_\_\_\_\_

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

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

10. Usual occupation Retired

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

11. Industry or business \_\_\_\_\_  
 12. Name No Record  
 13. Birthplace No Record  
 (City, town, or county) (State or foreign country)  
 14. Maiden name No Record  
 15. Birthplace No Record  
 (City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Mildred Creager  
 (b) Address 8805 Lexington,  
 17. (a) Burial (b) Date thereof Sept. 16-43  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Forest Hill Cemetery  
 18. (a) Signature of funeral director Sheil Funeral Home  
 (b) Address 6606 Indep. Ave. K.C. Mo.  
 19. (a) 9-15-1943 (b) James W. Ross  
 (Date received local registrar) (Registrar's signature)

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) (e) Means of injury \_\_\_\_\_  
 23. Signature William R. Egan M.D. or other REG.  
 Address Independence, Mo. Date signed 9/13/43

116.3

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**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 with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. *WV*Registration District No. *146*Primary Registration District No. *0-5-68*Registrar's No. *233*

## 1. PLACE OF DEATH:

- (a) County *Jackson*  
 (b) City or town *Blue Township*  
 (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 *Thomas Joshua Beaman*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 *M*

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years7. Birth date of deceased *Jan 8 1926*

(Month)

(Day)

(Year)

8. AGE:

Years *82*Months *8*

Days

If less than one day

min.

9. Birthplace *Mo*

(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)

(Date received local registrar)

(b)

(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Sept*  
year *1943* hour \_\_\_\_\_ minute \_\_\_\_\_ M.21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.Immediate cause of death *hyperstatis!* Duration \_\_\_\_\_*pneumonia**Sub Maxillary both sides*Due to *multiple metastasis**carcinoma*

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings: *55e*  
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) (e) Means of injury \_\_\_\_\_

23. Signature *Walt Beaman* (M.D. or other) *W*Address \_\_\_\_\_ Date signed *12/25/43*

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

SUPPLEMENTARY

34902