

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **21086**

FILED JUN 27 1950

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **256** PRIMARY REG. DIST. NO. **5879** Registrar's No. **9**

|   |                                   |  |  |
|---|-----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Osage</b>           |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Osage</b> |  |
| b. CITY OR TOWN <b>Chamois</b>                        | c. LENGTH OF STAY (In this place) | c. CITY OR TOWN <b>Benton Township</b> <b>0760</b>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>R.F.D.</b> |                                   | d. STREET ADDRESS (If rural, give location) <b>0</b>   |  |

|   |                               |   |  |  |  |
|---|-------------------------------|---|--|--|--|
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <b>Mary</b> b. (Middle) <b>America</b> c. (Last) <b>Becklenberg</b> |                               |   | 4. DATE OF DEATH (Month) (Day) (Year) <b>June 7 1950</b>         |  |  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b> ✓ | 8. DATE OF BIRTH <b>Feb 26 1869</b>                              |  | 9. AGE (In years last birthday) <b>81</b> Months <b>3</b> Days <b>3</b> Hours <b>3</b> Mins. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>          |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>usual work</b>                     | 11. BIRTHPLACE (State or foreign country) <b>Osage County Mo</b> |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 13a. FATHER'S NAME <b>Daniel Hunter</b>                                 |  | 13b. MOTHER'S MAIDEN NAME <b>Edile Brock</b> |  | 14. NAME OF HUSBAND OR WIFE <b>Mrs. Joest Becklenberg</b>                             |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ |  | 16. SOCIAL SECURITY NO. _____                |  | 17. INFORMANT'S SIGNATURE OR NAME <b>August Becklenberg</b> ADDRESS <b>Chamois Mo</b> |  |

|  |  |  |  |  |                                  |
|--|--|--|--|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. |  | MEDICAL CERTIFICATION                      |  |  | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary occlusion</b>   |  | DUPLICATE OF (b) <b>Arteriosclerosis</b>   |  |  | DUPLICATE OF (c) <b>years</b>    |
| ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  |  | DUPLICATE OF (c) <b>Coronary occlusion</b> |  |  |                                  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |  |  |  |  | <b>4/201</b>                     |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19a. DATE OF OPERATION                                |  | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)              |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)                       |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?  |  |

22. I hereby certify that I attended the deceased from **1947**, to **6/10/1950**, that I last saw the deceased alive on **any**, 19**47**, and that death occurred at **6:20 p.m.**, from the causes and on the date stated above.

|  |  |                                 |  |                                 |  |
|--|--|---------------------------------|--|---------------------------------|--|
| 23a. SIGNATURE <b>J.E. Giffen D.O.</b> (Degree or title) |  | 23b. ADDRESS <b>Chamois, Mo</b> |  | 23c. DATE SIGNED <b>6/12/50</b> |  |
|--|--|---------------------------------|--|---------------------------------|--|

|   |                          |   |   |  |  |
|---|--------------------------|---|---|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> | 24b. DATE <b>6-12-50</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b> | 24d. LOCATION (City, town, or county) (State) <b>Chamois Mo</b> |  |  |
|---|--------------------------|---|---|--|--|

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| DATE REC'D BY LOCAL REG. <b>June 12, 1950</b> | REGISTRAR'S SIGNATURE <b>Ether Souder</b> <b>284</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Chyle Martin</b> ADDRESS <b>Lin, Mo</b> |  |  |
|---|--|--|---|--|--|

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

RECEIVED  
JUN 19 1950  
District Health Officer No. 9,  
District File Number

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed.....  
Student Embalmer

Signed Vernon M. Morton

Licensed Embalmer No. 4125

P. O. Address Linn, Mo

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.