

FILED JAN 29 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 197

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 75

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

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Agency	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Josephs Hospital		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) Edward b. (Middle) Ray c. (Last) Beam			4. DATE OF DEATH (Month) (Day) (Year) Jan. 20 1951			
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH Sept. 18, 1946	9. AGE (In years last birthday) 4	IF UNDER 1 YEAR Months Days	IF UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME William Ray Beam		13b. MOTHER'S MAIDEN NAME Betty Marie Sexton		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Wm. R. Beam Agency, Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) HEMORRHAGE, GASTRO-INTESTINAL		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) LEUKEMIA, ACUTE LYMPHATIC			4 MONTHS
	DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			2040	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 11-28 1950, to 1-20, 1951, that I last saw the deceased alive on 1-20, 1951, and that death occurred at 4:20 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Allen Sherman M.D.		23b. ADDRESS 620 Francis St.		23c. DATE SIGNED 1-22-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 1/22/51	24c. NAME OF CEMETERY OR CREMATORY Harrödsburg		24d. LOCATION (City, town, or county) (State) Kentucky	
DATE REC'D BY LOCAL REG. Jan 24, 1951	REGISTRAR'S SIGNATURE Carl E. Castle	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Heaton-Bowman Funeral Home St. Joseph, Mo.			

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed William Spalding  
Licensed Embalmer No. 4535

P. O. Address 3195 10th St. Joseph, 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.