

THE DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

8244

State File No. ....

FILED APR 5 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 319

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u> <u>0396</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>		c. LENGTH OF STAY (In this place) <u>62 months</u>	c. CITY OR TOWN <u>Springfield</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mercy Infirmary</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		e. STREET ADDRESS (If rural, give location) <u>511 Normal Street</u>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <u>WILLIAM</u>	b. (Middle) <u>ROBERT</u>	c. (Last) <u>BEATIE</u>	(Month) <u>March</u>	(Day) <u>26</u>	(Year) <u>1954</u>

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>28 Oct. 1866</u>	9. AGE (In years last birthday) <u>87</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Medical Doctor</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Greene County, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>David M. Beatie</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Rose Beatie</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>	16. SOCIAL SECURITY NO. <u>----</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Orene Turner</u> ADDRESS <u>1239 S. National Avenue, Springfield, Missouri</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>April 1953</u>  <u>1953</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Congestive heart failure Myocardial Disease. Left ventricular hypertrophy</u>		
	ANTECEDENT CAUSES DUE TO (b) <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (c) <u>Arteriosclerosis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>422 h</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 4/19, 1953, to 3/26, 1954, that I last saw the deceased alive on 3/26, 1954, and that death occurred at 1:45 P m., from the causes and on the date stated above.

23a. SIGNATURE <u>O. G. Horst</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>430 S. West Ave Springfield Mo</u>	23c. DATE SIGNED <u>3/28/1954</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>28 Mar. 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri.</u>
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DATE REC'D BY LOCAL REG. <u>4-1-54</u>	REGISTRAR'S SIGNATURE <u>Edith Williams</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Paul C. Henry</u> ADDRESS <u>Springfield, Missouri</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

FEB 2 1955

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.....  
Signature of Student Embalmer

Signed *Frank C. Thomas*.....

Licensed Embalmer No. 2899  
Springfield,  
P. O. Address Missouri,.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.