

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **8075**  
42 1000 Registrar's No. **343**

FILED APR 2 1956

No. 300  
10.48

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

BIRTH NO. _____		REG. DIST. NO. <b>42</b>		PRIMARY REG. DIST. NO. <b>1000</b>		Registrar's No. <b>343</b>	
1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>			
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Joseph</b>		c. LENGTH OF STAY (in this place) <b>12 yrs.</b>		c. CITY OR TOWN <b>St. Joseph</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Willis Memorial Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>2529 South 15th Street</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>CHRISTINA</b>			b. (Middle) _____			c. (Last) <b>BEAGLE</b>	
4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>1956</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>Nov. 15, 1861</b>		9. AGE (In years last birthday) <b>94</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Pennsylvania</b>		12. CITIZENRY OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>John Reed</b>			13b. MOTHER'S MAIDEN NAME <b>Sarah (unknown)</b>			14. NAME OF HUSBAND OR WIFE <b>Daniel A. Beagle (Deceased)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Andrew McCush</b> ADDRESS <b>St. Joseph, Mo.</b>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
ANTECEDENT CAUSES DUE TO (b) <b>arterio sclerosis</b>				<b>not sure</b>			
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <b>bronchitis</b>				<b>not</b>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>33ix</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE OR 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 <b>March 10, 1956</b> , to <b>March 22, 1956</b> , that I last saw the deceased alive <b>March 22, 1956</b> , and that death occurred at <b>8:55P m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Colles Rowland MD</b>				23b. ADDRESS <b>Kirtzpatrick Bldg City</b>		23c. DATE SIGNED <b>March 23-56</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>3-23-56</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Savannah Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Savannah Missouri</b>	
DATE REC'D BY LOCAL REG. <b>Mar. 30, 1956</b>		REGISTRAR'S SIGNATURE <b>Kathleen M. Allison</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Stamey Funeral Home</b> ADDRESS <b>St. Joseph, Mo.</b>			

(Licensed Embalmer's Statement on Reverse Side)

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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed. *Charles E. Bennett*.....

Licensed Embalmer No. *4627*

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