

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **78339**
Registrar's No. **85**

FILED APR 8 - 1957

Registration District No. **47** Primary Registration District No. **3008**

Health, Welfare, Public Service

300-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <i>Callaway</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Saline</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Fulton</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Marshall</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>State Hosp # 1</i>		Length of stay in lb <i>15 weeks</i>		d. STREET ADDRESS (If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Silas</i> Middle <i>Beall</i> Last <i>Beall</i>			4. DATE OF DEATH Month <i>3</i> Day <i>30</i> Year <i>57</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-8-1879</i>	9. AGE (In years last birthday) <i>76</i>	IF UNDER 1 YEAR Months <i>7</i> Days <i>6</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>		11. BIRTHPLACE (City and state or country) <i>Whiting, Kansas</i>	
13. FATHER'S NAME <i>S. P. Beall</i>			14. MOTHER'S MAIDEN NAME <i>Susie R Schooling</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes <i>World War I</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT Address <i>State Hospital No. 1; Fulton, Missouri</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>arteriosclerosis</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a) <i>4201</i>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. attended the deceased from <i>State Hospital No. 1</i> <i>Dec. 18, 1956</i> , to <i>Mar. 30, 1957</i> and last saw <i>her</i> alive on <i>3-30-57</i> Death occurred at <i>8:40 p.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Norm Ceathey MD</i>			22b. ADDRESS <i>State Hosp # 1</i>		22c. DATE SIGNED <i>4-1-57</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>3/31/57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>OK</i>		23d. LOCATION (City, town, or county) (State) <i>Sweet Springs Mo,</i>
24. FUNERAL DIRECTOR <i>Maupin</i>		ADDRESS <i>Fulton Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>April-5-1957</i>	26. REGISTRAR'S SIGNATURE <i>Maretha Lawrence</i>

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 *Ray A. Stewart*

Licensed Embalmer No. *37*

P. O. Address *Fulton*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.