

FILED APR 8 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

83889

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 5466 Registrar's No. 307

1. PLACE OF DEATH a. COUNTY <u>GREENE 390</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>	
b. CITY OR TOWN <u>ST. CAMPBELL</u> <small>(If outside, complete, give TOWNSHIP only)</small> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>SPRINGFIELD 390</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ROUTE 9 1</u>		Length of stay in 1b <u>20 YRS</u>	
d. STREET ADDRESS <u>ROUTE 9</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>B.</u> Last <u>BECKERLEG</u>			4. DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>1957</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-20-1886</u>
9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. R.R. ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN BECKERLEG</u>	
14. MOTHER'S MAIDEN NAME <u>PETTA WAITS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>702-07-2117</u>		17. INFORMANT Address <u>EDNA BECKERLEG RT. 9</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>W. disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH. <u>1-2 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4201</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 _____ a. m. _____ p. m. _____ Month _____ Day _____ Year _____			
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. I attended the deceased from _____ to <u>3-30-57</u> and last saw her alive on _____ Death occurred at <u>12:30 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>S. B. Emmerson</u> (Degree or title)		22b. ADDRESS <u>Springfield, Mo.</u>	22c. DATE SIGNED <u>3-30-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>4-2-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EASTLAWN CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD, MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>J.W. KLINGNERT & CO SPFLD. MO.</u>		25. DATE RECD. BY LOCAL REG. <u>4-3-57</u>	26. REGISTRAR'S SIGNATURE <u>Walter G. Williamson</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

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Health,
Welfare
Public
Service

APR 9 1957

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 *Mal Rhodes*

Licensed Embalmer No. *40*

P. O. Address *Spring*

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