

Health,
Welfare
Public
Service

FILED JUL 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25207

STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. 5626 Registrar's No. 109

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LEBANON T.S.</u>		c. CITY OR TOWN <u>Lebanon</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Long Nursing H.</u>		d. STREET ADDRESS (If outside, give location) <u>Linn Creek Star Rt.</u>	
Length of stay in lb <u>1 Year</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>ERNEST F. BEANS</u>			4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1957</u>		
---	--	--	---	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 21, 1880</u>	9. AGE (In years last birthday) <u>76</u>	10. UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
--------------------	-------------------------------	---	--	---	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	11. BIRTHPLACE (City and state or country) <u>Tina, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	--	---	--

13a. FATHER'S NAME <u>John T. Beans</u>	13b. MOTHER'S MAIDEN NAME <u>Not Known</u>	14. NAME OF HUSBAND OR WIFE <u>Not Known</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>—</u>	17. INFORMANT Address <u>Laclede County Welfare Office</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>Viral Hypostatic Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>30 Min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cardiac Decompensation</u>	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>492X</u>	

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 <u>8:30</u> Month <u>July</u> Day <u>7</u> Year <u>1957</u> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Lebanon, Mo.</u>	COUNTY <u>Laclede</u> STATE <u>Mo.</u>
---	--	--	--

21. I attended the deceased from July 7, 1957 to July 9, 57 and last saw her alive on July 9, 1957
Death occurred at 8:30 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>O. B. Baker</u> (Degree or title) <u>D.O.</u>	22b. ADDRESS <u>117 N. Jefferson, Lebanon, Mo.</u>	22c. DATE SIGNED <u>7-9-57</u>
---	--	--------------------------------

23a. BURIAL, CREMATION, etc. (Specify) <u>Burial</u>	23b. DATE <u>7/11/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lebanon City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Lebanon, Mo.</u>
--	--------------------------	---	---

24. FUNERAL DIRECTOR <u>J. M. Palmer</u> ADDRESS <u>Lebanon, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>7-10-1957</u>	26. REGISTRAR'S SIGNATURE <u>Hella L. Way</u>
--	---	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in their reports - no symptoms will be listed. All diseases in Part I must be causally related.

Received 7-15-57

Laclede County Health Unit

File No. 109

Date Filed 7-15-57

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 Stanley R. Palmer

Licensed Embalmer No. 4810

P. O. Address Lebanon, 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.