

Health,  
& Welfare  
Public  
Service

S. 300  
v. 1-56

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

FILED NOV 6 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36624

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 429

1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Marion</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Leveering Hosp.</u>			Length of stay in lb <u>18 days</u>		d. STREET ADDRESS <u>3319 Helen Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Arthur</u> Last <u>Beam</u>			4. DATE OF DEATH Month <u>10</u> Day <u>24</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"/>	8. DATE OF BIRTH <u>Dec 2, 1886</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF 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>Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Motel</u>		11. BIRTHPLACE (City and state or country) <u>Molino, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>J.N. Beam</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Heizer</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.		17. INFORMANT <u>Susie Beam</u> Address <u>Hannibal, Mo.</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>Terminal bronchial pneumonia</u> DUE TO (b) <u>Carcinoma right colon</u> DUE TO (c) <u>153X</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Exploratory laporotomy 10/18/57 revealed adeno-carcinoma with metastasis into omentum</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>unknown</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>8:55</u> Month <u>10</u> Day <u>18</u> Year <u>1957</u> a. m. <u>A</u> 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 <u>Hannibal, Mo.</u>		STATE	
21. I attended the deceased from <u>10/5/57</u> to <u>10/24/57</u> and last saw <u>her</u> alive on <u>10/24/57</u> Death occurred at <u>8:55 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>				22b. ADDRESS <u>100 N. 6th, Hannibal, Mo.</u>		22c. DATE SIGNED <u>10/29/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-26-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Olivet Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hannibal, Mo.</u>		
24. FUNERAL DIRECTOR <u>Alph Clark F.,</u> ADDRESS <u>Funeral Home - Hannibal, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>10/31/57</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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RECEIVED NOV 5 1957

MARION CO. HEALTH DEPT.

DATE FILED NOV 5 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

*Ralph Clark*

Licensed Embalmer No. 421

P. O. Address Hannibal, 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.