

Health,  
Welfare  
Public  
Service

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1-56

0542  
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All  
diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

*On Dec 1*

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044738  
STATE FILE NUMBER

FILED JAN 9 1959 Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 1

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Wellington 0546</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>Lexington Mem. Hosp</u>			Length of stay in lb <u>1 day</u>	d. STREET ADDRESS (If outside, give location) <u>Rural</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>HENRY</u> Last <u>BEINING</u>				4. DATE OF DEATH Month <u>December</u> Day <u>24</u> Year <u>1958</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>March 5, 1895</u>		9. AGE (In years last birthday) <u>63</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Wellington, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Beining</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Shorman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes World War I</u>		16. SOCIAL SECURITY NO. <u>not known</u>		17. INFORMANT Address <u>Mrs. Clara Beining Wellington, 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>Coronary thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Previous attacks year ago</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4201</u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</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.) <u>4201</u>				
20c. TIME OF INJURY Hour _____ 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. I attended the deceased from <u>4/1/58</u> to <u>12/24/58</u> and last saw her alive on <u>12/24/58</u> Death occurred at <u>11:30 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Ben H. Brasher MD</u>				22b. ADDRESS <u>Lexington, Mo.</u>		22c. DATE SIGNED <u>12/26/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/27, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Wellington, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>J. C. Sheppard Wellington, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>1-2-59</u>		26. REGISTRAR'S SIGNATURE <u>Thomas G. Eastbrook</u>		

(Licensed Embalmer's Statement on Reverse Side)

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1959 FEB 8

VS  
AUG 16 1960

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 *J. Clair Shepper*

Licensed Embalmer No. *412*

P. O. Address *Wellington*

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.