

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-005408

STATE FILE NUMBER

FILED FEB 17 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 469

300  
-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Madaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Skidmore</u> 0748 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Childrens Mercy Hosp 12 hrs</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Terry</u> Middle <u>ALLEN</u> Last <u>BEASON</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>24</u> Year <u>1959</u>		
--	--	--	---	--	--

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-5-59</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <u>19</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u>19</u> Min.
-----------------------	----------------------------------	---	-----------------------------------	---------------------------------	--	--

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

13a. FATHER'S NAME <u>Clarence Beason</u>	13b. MOTHER'S MAIDEN NAME <u>Aldridge, Mary</u>	14. NAME OF HUSBAND OR WIFE <u>-</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>none</u>	17. INFORMANT <u>Father</u>	Address <u>Skidmore, 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>Bilateral bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>none</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)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u>9 a.m.</u> Month, Day, Year	20d. INJURY OCCURRED WHILE AT <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>Skidmore, Mo.</u>	COUNTY	STATE
--	---	---	--	--------	-------

21. I attended the deceased from <u>9 P.M. 1-23-59</u> to <u>9 A.M. 1-24-59</u> and last saw her alive on <u>1-24-59</u> Death occurred at <u>9 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <u>R.D. Partman M.D.</u>	(Degree or title)	22b. ADDRESS <u>Childrens Mercy Hospital</u>	22c. DATE SIGNED <u>1-24-59</u>
--	-------------------	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-25-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>-</u>	23d. LOCATION (City, town, or county) (State) <u>Skidmore, Mo.</u>
---	-----------------------------	--	---

24. FUNERAL DIRECTOR <u>Trueman Home MO</u>	ADDRESS <u>MARYVILLE</u>	25. DATE RECD. BY LOCAL REG. <u>1-25-59</u>	26. REGISTRAR'S SIGNATURE <u>neva minshall</u>
--	-----------------------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

R. D. Partman

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Clum M. Trigg* .....

Licensed Embalmer No. *1822* .....

P. O. Address *Manassasville* .....

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.