

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008443
STATE FILE NUMBER

FILED MAR 23 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 277

300
-57

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Buchanan</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Joseph</i> 117		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <i>Missouri Methodist Hospital</i>		Length of stay in lb <i>56 years</i>	d. STREET ADDRESS (If outside, give location) <i>610 E. Missouri Ave.</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>W.</i> Last <i>Beard</i>			4. DATE OF DEATH Month <i>March</i> Day <i>14</i> Year <i>1959</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 26, 1879</i>	9. AGE (In years last birthday) <i>79</i>	10. FUNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Mechanic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Auto Repair</i>	11. BIRTHPLACE (City and state or country) <i>Ringgold County Iowa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13a. FATHER'S NAME <i>Albert Beard</i>		13b. MOTHER'S MAIDEN NAME <i>Laura Leason</i>		14. NAME OF HUSBAND OR WIFE <i>Bess M. Beard</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>497-10-1556</i>	17. INFORMANT <i>Mrs. James W. Beard</i> Address <i>610 E. Mo. Ave.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>					INTERVAL BETWEEN ONSET AND DEATH <i>14 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Coronary Atherosclerosis</i>					Unknown
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>4201</i>					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 Month, Day, Year 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 <i>3-5-59</i> to <i>3-14-59</i> and last saw her/him alive on <i>3-14-59</i> Death occurred at <i>6:15 p</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Allen I. Herman M.D.</i>			22b. ADDRESS <i>706 Francis St. Joseph, Mo.</i>		22c. DATE SIGNED <i>3-17-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>March 17, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Joseph, Mo.</i>	
24. FUNERAL DIRECTOR <i>Clark Funeral Home St. Joseph, Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>Mar. 18, 1959</i>		26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Stoddell</i>	

All diseases in Part I must be causally related.

Dr. Allen I. Herman

MEDICAL CERTIFICATION 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 *Albert C. Bazar*

Licensed Embalmer No. *4795*

P. O. Address *St. Joseph 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.