

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012658

STATE FILE NUMBER

FILED MAY 13 1959

Registration District No. 70

Primary Registration District No.

Registrar's No. 25

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5. 300  
1-57

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1. PLACE OF DEATH a. COUNTY <u>Clark</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Levers</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kahoka</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Williamstown</u> 0.568 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>Mitchell Rest Home</u>		Length of stay in 1b <u>2 yr.</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fred Emmet Beard</u>			4. DATE OF DEATH Month Day Year <u>April 29-1959</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>March 24-1893</u>
9a. USUAL OCCUPATION (Give kind of work done during most of adult life, even if retired) <u>Farmer</u>		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years) (If UNDER 1 YEAR, IF UNDER 24 HRS., give Months, Days, Hours, Min.) <u>66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of adult life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Eugene Beard</u>	
13b. MOTHER'S MAIDEN NAME <u>Minnie Frances Moore</u>		14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes World War I</u>		16. SOCIAL SECURITY NO. <u>489-42-2128</u>	17. INFORMANT <u>Myrtle Beard</u> Address <u>Alexandria Mo</u>
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary failure</u> DUE TO (b) <u>Cardiac decompensation</u> DUE TO (c) <u>Overwhelming toxemia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Burns, Paralysis agitans, pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>minutes</u> <u>Days</u>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <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>7-7-58</u> to <u>4-29-59</u> and last saw her <u>live</u> on <u>4-29</u> Death occurred at <u>4:30 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert L. Willis</u>		22b. ADDRESS <u>Kahoka Mo</u>	22c. DATE SIGNED <u>5-4-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>May 2-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Tragee Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Clark Co. Mo</u>
24. FUNERAL DIRECTOR <u>Wes L. Tuttle - Kahoka Mo</u>		25. DATE RECD. BY LOCAL REG. <u>5/4-59</u>	26. REGISTRAR'S SIGNATURE <u>J. B. Rogers</u>

(Licensed Embalmer's statement on Reverse 59a)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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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 *Oliver L. Sutter* .....

Licensed Embalmer No. *2965* .....

P. O. Address *La Plata* .....

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.