

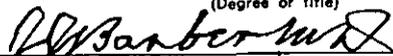
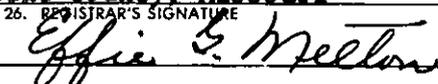
# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024720

FILED VS AUG 3 1959 28

Registration District No. 28 Primary Registration District No. 2000 Registrar's No. 792

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Greene</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b> Length of stay in lb c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Baptist Hospital</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b> c. CITY OR TOWN <b>Springfield</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>2916 W. Lynn</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> First <b>TERRY</b> Middle <b>JANE</b> Last <b>BEACH</b> (Type or print)			<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>24</b> Year <b>1959</b>				
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>22 July 1959</b>	<b>9. AGE (last birthday)</b> <b>0</b>	<b>IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>2</b>	<b>IF UNDER 24 HR</b> Hours <b></b> Min. <b></b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Infant</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Infant</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Springfield, Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>	
<b>13a. FATHER'S NAME</b> <b>Rex Beach</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Screna Breedlove</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>None</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			<b>16. SOCIAL SECURITY NO.</b> <b>No</b>		<b>17. INFORMANT</b> Address <b>Hospital Records</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MOTHER PAINTED ROOM WHICH CAUSED</b> DUE TO (b) <b>ABORTION OF FOUR POUND FETUS THAT</b> DUE TO (c) <b>LIVED IN INCUBATOR TWO DAYS.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour <b></b> Month, Day, Year <b></b> a.m. <b></b> p.m. <b></b>		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		<b>STATE</b>	
<b>21. I attended the deceased from</b> <u>7-22-59</u> <b>to</b> <u>7/24/59</u> <b>and last saw her</b> <u>7-24-59</u> <b>alive on</b> Death occurred at <u>2:10</u> <b>P</b> <b>m</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) 				<b>22b. ADDRESS</b> <b>Walnut Grove, Missouri</b>		<b>22c. DATE SIGNED</b> <b>7-26-59</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE</b> <b>7/25/59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rose Hill</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Greene County, Missouri</b>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>J.W. KLIGNNER &amp; CO. Springfield, Mo.</b>			<b>25. DATE RECD. BY LOCAL REG.</b> <b>7-29-59</b>		<b>26. REGISTRAR'S SIGNATURE</b> 		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Max B. [Signature]

Licensed Embalmer No. 40

P. O. Address [Signature]

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.