

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032831

FILED VS. OCT 13 1959 159

Registration District No. 159 Primary Registration District No. 5591 Registrar's No. 62

STATE FILE NUMBER

DEED

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Jefferson</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jeff.</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hillsboro Mo</u> | | Length of stay in 1b <u>22 mos</u> | c. CITY OR TOWN <u>CATAWISSA Mo</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home Castle Acres Nursing</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>R. R.</u> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>CLAUDE Alexander BEA</u> | | 4. DATE OF DEATH Month Day Year <u>9 - 7 - 59</u> | |

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|-----------------|---------------------------|--|-----------------------------------|----------------------------------|-----------------------------|---------------------------|
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/10/1896</u> | 9. AGE (last birthday) <u>68</u> | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
|-----------------|---------------------------|--|-----------------------------------|----------------------------------|-----------------------------|---------------------------|

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

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|--------------------------------------|--|---|
| 13a. FATHER'S NAME <u>GEORGE BEA</u> | 13b. MOTHER'S MAIDEN NAME <u>Florence Simm</u> | 14. NAME OF HUSBAND OR WIFE <u>LENA BEA</u> |
|--------------------------------------|--|---|

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW-1</u> | 16. SOCIAL SECURITY NO. <u>NONE</u> | 17. INFORMANT Address <u>BERNARD Schewe CATAWISSA Mo</u> |
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|---|--|--|
| 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>adeno-carcinoma lung</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |
| 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 |

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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 a.m. p.m. _____ | Month, Day, Year _____ | |
| 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 Nov 5 8 to Sept 7, 59 and last saw him alive on Aug 19, 59
Death occurred at 8:10 A m on the date stated above, and to the best of my knowledge from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>NOEL V. REYNOLDS M.D.</u> | 22b. ADDRESS <u>Desoto, Mo.</u> | 22c. DATE SIGNED (State) <u>Sept 8, 59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>9/9/59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL Cem.</u> |
| 23d. LOCATION (City, town, or county) <u>Jefferson Bks Mo</u> | 24. FUNERAL DIRECTOR ADDRESS <u>Bernard Schewe Catawissa Mo</u> | 25. DATE RECD. BY LOCAL REG. <u>9-8-59</u> |
| 26. REGISTRAR'S SIGNATURE <u>Blair R. ...</u> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS OCT 14 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Ralph Ottmann

Licensed Embalmer No. 4808

P. O. Address Union, 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.