

Dept. Health,  
oc., & Welfare  
I. S. Public  
Health Service

V. S. 300  
Rev. 1-57

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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

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FILED VS SEP 3 0 1959

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 340 Primary Registration District No. 6150 Registrar's No. 83

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>New Lisbon</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1</u>		Length of stay in lb		1038 STREET ADDRESS <u>Puxico R#1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Dave</u> Middle <u>—</u> Last <u>Beal</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>17</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 type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 26 1881</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Leora Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>William Beal</u>			13b. MOTHER'S MAIDEN NAME <u>Christine Siffors</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>492-42-3778</u>		17. INFORMANT <u>Mrs Claude Townsend Puxico Mo</u> Address				
18. CAUSE OF DEATH (Enter only one cause per life for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</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)						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.) <u>4201</u>					
20c. TIME OF INJURY Hour _____ 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 <u>Jan 1 1931</u> to <u>Sept 17 1959</u> and last saw her/him alive on <u>Sept 16 1959</u> Death occurred at <u>8:39 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>[Signature]</u> (Degree or title)				22b. ADDRESS <u>[Address]</u>		22c. DATE SIGNED <u>9-21-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-19-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>9292n</u>		23d. LOCATION (City, town, or country) (State) <u>Puxico R#1 Mo</u>			
24. FUNERAL DIRECTOR <u>Floyd Morgan Puxico Mo</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>9-23-59</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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 ..... *W<sup>m</sup> H. Morgan* .....

Licensed Embalmer No. *4640* .....

P. O. Address... *Advance, N.Y.* .....

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.