

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | | | |
|--|---|---|---|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri. b. COUNTY Crawford | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. | | Length of stay in 1b | | c. CITY OR TOWN Steelville | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hospital | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Box 313 | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Maude Middle A. Last Beckham | | | 4. DATE OF DEATH Month February Day 25 Year 1961 | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 12/5/1884 | 9. AGE (last birthday) 76 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (City and state or country) Steelville, Missouri. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Anderson Marsh | | 13b. MOTHER'S MAIDEN NAME Emma Burke | | 14. NAME OF HUSBAND OR WIFE John Beckham | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO. Nil. | | 17. INFORMANT Lois Beckham, Springfield, Mo. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE AURICULAR FIBRILLATION MALNUTRITION SEVERE DUE TO (b) Polyp of sigmoide bleeding DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200 | | | | | | | INTERVAL BETWEEN ONSET AND DEATH YEARS 2 mo |
| 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.) 4200 | | | | |
| 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 Feb 23 1961 to Feb 25 '61 and last saw ^{her} _{him} alive on Feb 25 '61 Death occurred at 1:20 pm on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) Waverly M. Foreman MD | | | | 22b. ADDRESS St. Louis 8 Mo | | 22c. DATE SIGNED 2/27/61 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 2-25-61 | 23c. NAME OF CEMETERY OR CREMATORY Local | | 23d. LOCATION (City, town, or county) Steelville, Mo. | | 23e. REGISTRAR'S SIGNATURE Lois Smith, M.D. | |
| 24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe Inc., 4700 Washington, Blvd. | | | | 25. DATE RECD. BY LOCAL REG. FEB 27 1961 | | 26. REGISTRAR'S SIGNATURE | |

MAR 14 1961

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 John J. Harris

Licensed Embalmer No. 4108

P. O. Address St. Louis, 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.