

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

10 21839

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 0021839

STATE FILE NUMBER

MY FILED 26 64

VS 300  
Rev. 4/59

1 1086  
2 0390

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4 0  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY - - - <b>Vernon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Nevada</b>		Length of stay in 1b <b>2 yrs</b>	c. CITY OR TOWN <b>Springfield</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital No. 3</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Route 11, Box 1310</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Warner Beasley</b>			4. DATE OF DEATH Month Day Year <b>May 21 1964</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-11-92</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	9. AGE (last birthday) <b>71</b>
11. BIRTHPLACE (City and state or country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>William J. Beasley</b>		13b. MOTHER'S MAIDEN NAME <b>Mary McCowan</b>	
14. NAME OF HUSBAND OR WIFE <b>Deceased</b>		17. INFORMANT Address <b>Records-State Hospital No. 3</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Several years</b> <b>Years</b>
DUE TO (b) <b>Arteriosclerosis</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) <b>back. Old happened March 12, 1964 in a nursing home in Springfield.</b>			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
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 Month, Day, Year s.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 <b>3-9-62</b> to <b>4-21-64</b> and last saw him <input checked="" type="checkbox"/> alive on <b>4-21-64</b> Death occurred at <b>7:30 a.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Paul L. Barone MD Sup't.</b>		22b. ADDRESS <b>State Hospital #3 Nevada, Missouri</b>	
22c. DATE SIGNED <b>4-21-64</b>		23d. LOCATION (City, town, or county) (State) <b>Stockton, Mo.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>5/21/64</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>City</b>		23d. LOCATION (City, town, or county) (State) <b>Stockton, Mo.</b>	
24. FUNERAL DIRECTOR <b>Cantlon Funeral Home Stockton, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>5-21-1964</b>	
26. REGISTRAR'S SIGNATURE <b>Anna E. Ferry</b>			

(Licensed Embalmer's Statement on Reverse Side)

MAY 28 1964

**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 *Lloyd C. Moore*

Licensed Embalmer No. 4853

P. O. Address *Florida, Fla.*

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.