

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-011151
STATE FILE NUMBER

FILED APR 8 1958

Registration District No. 297 Primary Registration District No. 6022 Registrar's No. 26

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-57
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1. PLACE OF DEATH a. COUNTY <u>Ray</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Richmond</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ray County Memorial Hospital 6 months</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>R.P.D. # 3 miles SW Richmond</u>
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>ANNE</u> Last <u>Beklis</u>			4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1958</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9, 1884</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Manufacturing</u>	9c. AGE (In years last birthday) <u>74</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	10c. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
11. BIRTHPLACE (City and state or country) <u>Oriskany, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James O. Williams</u>		13b. MOTHER'S MAIDEN NAME <u>Nellie Krummer</u>	
14. NAME OF HUSBAND OR WIFE <u>Alroy Beklis</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>none</u>		17. INFORMANT <u>Mr. Boyd Puffett, Oriskany, Mo.</u>	
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>Cerebral hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<u>331X</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Rheum a toid arthritis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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 _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		20f. CITY, TOWN, OR LOCATION <u>Richmond, Mo.</u>	
20g. COUNTY _____		20h. STATE _____	
21. I attended the deceased from <u>Oct. 8, 1953</u> to <u>March 24, 1958</u> and last saw her alive on <u>March 24, 1958</u> Death occurred at <u>5:48 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>M. Johnson</u> (Degree or title)		22b. ADDRESS <u>Richmond, Mo.</u>	
22c. DATE SIGNED <u>3/29/58</u>		22d. SIGNATURE <u>Mabel Jackson</u>	
23a. BURIAL, CREMATION, REBURY (Specify) <u>Burial</u>		23b. DATE <u>3-27-58</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>South Point</u>		23d. LOCATION (City, town, or county) (State) <u>Oriskany, Missouri</u>	
24. FUNERAL DIRECTOR <u>Lucy E. Furrer & Hays</u> <u>Richmond, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>4-2-1958</u>	
26. REGISTRAR'S SIGNATURE <u>Mabel Jackson</u>		26. REGISTRAR'S SIGNATURE <u>Mabel Jackson</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 

Licensed Embalmer No. 4065
P. O. Address Bellevue, Wis.

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.