WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

(36)

PLACE OF DEATH

County Pettis

Township _____ Registration District No. 668 File No. 5657

or

Village _____ Primary Registration District No. 3032 Registered No. 36

or

City Sedalia (NO. 3124 S 12th St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Wm. Taylor Beard

PERSONAL AND STATISTICAL PARTICULARS

SEX: M.

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: June 6, 1860 (Month) (Day) (Year)

AGE: 53 yrs. 8 mos. 1 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Machine Helper
(b) General nature of industry, business, or establishment in which employed (or employer): Rail Road Shops

BIRTHPLACE (City or town, State or foreign country): Missouri

PARENTS

NAME OF FATHER: Jas Colvin Beard

BIRTHPLACE OF FATHER (City or town, State or foreign country): Ind.

MAIDEN NAME OF MOTHER: Jane Williams

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): F. V. Beard

(ADDRESS): Marshall Mo Saline Co.

Filed Feb 9, 1914. F. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb 7, 1914 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 3, 1914, to Feb 6, 1914, that I last saw him alive on Feb 6, 1914, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Coma

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) _____

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) F. R. Morley M. D.

2/9, 1914 (Address) Sedalia Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Smithton, Mo.

DATE OF BURIAL: 2/91, 1914

UNDERTAKER: Sedalia Undt Co Pt Co

ADDRESS: Sedalia Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... or Village ..... or City ..... (NO. ..... St.; ..... Ward)

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*)

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191..., ...

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to ....., 191...., that I last saw h.....alive on ....., 191...., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory .....
(SECONDARY)

.....(Duration).....yrs. .....mos. .....ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191....
UNDERTAKER	ADDRESS