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 Adair

Township ____ or Village ____ or City Kirksville (NO. 216 S Main St.; ____ Ward)

Registration District No. 4 File No. 11497

Primary Registration District No. 3001 Registered No. 18

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

FULL NAME Martin L. Beeman

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: white

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

DATE OF BIRTH: Mar. 13, 1849 (Month) (Day) (Year)

AGE: 65 yrs. ~~26~~ mos. 26 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

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

BIRTHPLACE (City or town, State or foreign country): Kirksville Mo

PARENTS

NAME OF FATHER: Otho H. Beeman

BIRTHPLACE OF FATHER (City or town, State or foreign country): Ohio 8

MAIDEN NAME OF MOTHER: Catherine Burgender

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy H. Beeman

(ADDRESS) Jr 462 Jersey Ave Jersey City

Filed 4. 12. 1914 W. W. Parrish REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 4 (Month) 9 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from 4 9, 1914, to 4 9, 1914 that I last saw h____ alive on ____, 1914 and that death occurred, on the date stated above, at 8 15 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

He was dead when I arrived

95 B (Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) E. R. Lyda M. D.

Apr. 11, 1914 (Address) Kirksville 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: Kirksville Mo

DATE OF BURIAL: April 12 1914

UNDERTAKER: H. C. Wilson

ADDRESS: Kirksville

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

or

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

or

City ..... (NO. ....., ... St.; ..... Ward)

[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