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.

THIS IS A PERMANENT RECORD

PLACE OF DEATH

County Buchanan

Township Agency

or

Village Faucett, Mo

or

City ______ (NO. ______ St.: ______ Ward)

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

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

30577

Registration District No. 921 File No. ______

Primary Registration District No. 4557 Registered No. ______

FULL NAME Arthur J. Beeby

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

DATE OF BIRTH August 17, 1877 (Month) (Day) (Year)

AGE 45 yrs. 3 mos. 12 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) ______

BIRTHPLACE (City or town, State or foreign country) Faucett, Mo.

PARENTS

NAME OF FATHER Charles J. Beeby

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

MAIDEN NAME OF MOTHER Mary A. Roach

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William F. Beeby

(ADDRESS) Faucett Mo.

Filed Dec 7, 1922 W. M. [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH November 29, 1922 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 15, 1922, to Nov 29, 1922, that I last saw him alive on Nov 28, 1922, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Hypertrophied and Dilated Heart

(Duration) 2 yrs. — mos. — ds.

Contributory (SECONDARY) Defective Compensation

(Duration) — yrs. 18 mos. — ds.

(Signed) W. M. Mac[illegible] M. D.

90

______, 191__ (Address) Faucett 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	DATE OF BURIAL
Faucett, Mo.	Dec 1, 1922

UNDERTAKER	ADDRESS
Granger & Son	Faddonia Mo.

PLACE OF DEATH

County _____

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

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

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

_____ (Month) _____ (Day) 1_____ (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

WRITE PLAINLY, WITH UNFADING INK. [illegible]

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.