

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

Do not use this space.

14799

1. PLACE OF DEATH
 County St. Louis Registration District No. 318
 Township Springfield Primary Registration District No. 2001
 City Springfield (No. 622 S. Michigan) St. _____ Ward _____

2. FULL NAME Eliza Anna Beat
 (a) Residence. No. 570 S. New Ave. Ward _____
 (Usual place of abode) _____ (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 5 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** married

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF Geo. M. Beat

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 24 1868

| | | | | |
|---------------|-----------|-----------|-----------|----------------------------------|
| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, hrs. or min. |
| | <u>63</u> | <u>10</u> | <u>23</u> | |

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Illinois

10. NAME OF FATHER John Fetter

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Illinois

12. MAIDEN NAME OF MOTHER Elizanne Wittman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Illinois

14. INFORMANT Dr. Beat
 (Address) 570 S. New Ave.

15. FILED 5/19 1927 October Mrs
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-17 1927

17. I HEREBY CERTIFY That I attended deceased from April 1926, to 5-17 1927 that I last saw him alive on 5-8 1927, and that death occurred, on the date stated above, at 11:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy
8751
102 (duration) 74 yrs. mos. da.

CONTRIBUTORY (SECONDARY) Hypertension
 (duration) _____ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH NO DATE OF _____
20. WAS THERE AN AUTOPSY NO

WHAT TEST CONFIRMED DIAGNOSIS physical Exam
 (Signed) John W. Deane M. D.
18 of Springfield Mo. (Address)

State the DISEASE CAUSING DEATH or its death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL East Lawn **DATE OF BURIAL** 5/20 1927

20. UNDERTAKER W. Thomas ADDRESS Mo. 11

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.

JUN 30 1927

WHILE IN LINE, WITH OUTRADING INSTRUMENTS IS A PERMANENT RECORD

