

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

Do not use this space.

12492

1. PLACE OF DEATH
 County Callaway Registration District No. 104
 Township _____ Primary Registration District No. 3008
 City Fulton (No. _____) St. _____ Ward _____

File No. _____
 Registered No. 76

2. FULL NAME Sue Herndon Beaven
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 2 1851

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
76 6 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mo.
 (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Edward Sinclare Herndon

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

12. MAIDEN NAME OF MOTHER Ann Craig

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

14. E.W. Herndon
 INFORMANT (Address) Fulton Mo.

15. Filed Apr. 19, 1928 R. N. Crews
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/18/1928

17. I HEREBY CERTIFY That I attended deceased from April 10th, 1928 Date. _____ 19____
 that I last saw _____ alive on April 17th, 1928 _____ and that death occurred, on the date stated above, at 4 A.M. _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cardiac insufficiency, following protracted confinement from fractured hip.

CONTRIBUTORY (SECONDARY) Rheumatism
 (duration) _____ yrs. _____ mos. _____ da.
6 yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED 1868
1927
 IF NOT AT PLACE OF DEATH: _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? P.E.
 (Signed) Greene B. McCall _____ M. D.
 _____, 19____ (Address) Fulton Mo.

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Richland Christian Church DATE OF BURIAL 4/19 28

20. UNDERTAKER Herndon Taylor ADDRESS Fulton Mo.

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

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Callaway Registration District No. 104 File No.
Township Fullton Primary Registration District No. 3008 Registered No. 76
City Fullton (No.) St. Ward)

2. FULL NAME

Sue Hendon Beaver
(a) Residence No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE w. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) w.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 6-17-28 R. N. Crews REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/18 19 23

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Cardiac Insufficiency following protracted Rheumatism from fractured femur caused by fall March 31st 1927. Accidental.
CONTAGIOUS (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH 185

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Green M. & Callahan M. D.
, 19 (Address) Fullton mo.

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19.....

20. UNDERTAKER ADDRESS

CAUSE OF DEATH REGISTRATION SH
* so that it may be properly classified. Exact statement of OCCUPATION is very important.
PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY.
VE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-12492