

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

Do not use this space.

17797

1. PLACE OF DEATH

County Marion Registration District No. 547 File No. _____
 Township Marion Primary Registration District No. 3029 Registered No. _____
 City Hannibal (No. _____) St. Elizabeth Hospital _____ 136 _____ Ward

2. FULL NAME

James Beatty
 (a) Residence. No. 101 Hill 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 Male **4. COLOR OR RACE** Colord **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Single
 (write the word)
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.
about 30

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Self Drives Taxi
 (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)
Wichita Kansas

10. NAME OF FATHER Richard Beatty
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Little Rock Ark.
12. MAIDEN NAME OF MOTHER Hattie Love
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Little Rock Ark.

14. INFORMANT (Address) Mrs. Eva Hunter
Wichita Kansas

15. FILED 5/21/28 W. Estline REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-17-1928
17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____ that I last saw h_____ alive on _____, 19____, and that death occurred, on the date stated above, at _____, 9 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Brain Shot
through the temple. By Leo Wynn
 _____ (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

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

! DID AN OPERATION PRECEDE DEATH? DATE OF _____
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS.
 (Signed) Chas. R. Scott Coroner
19 _____

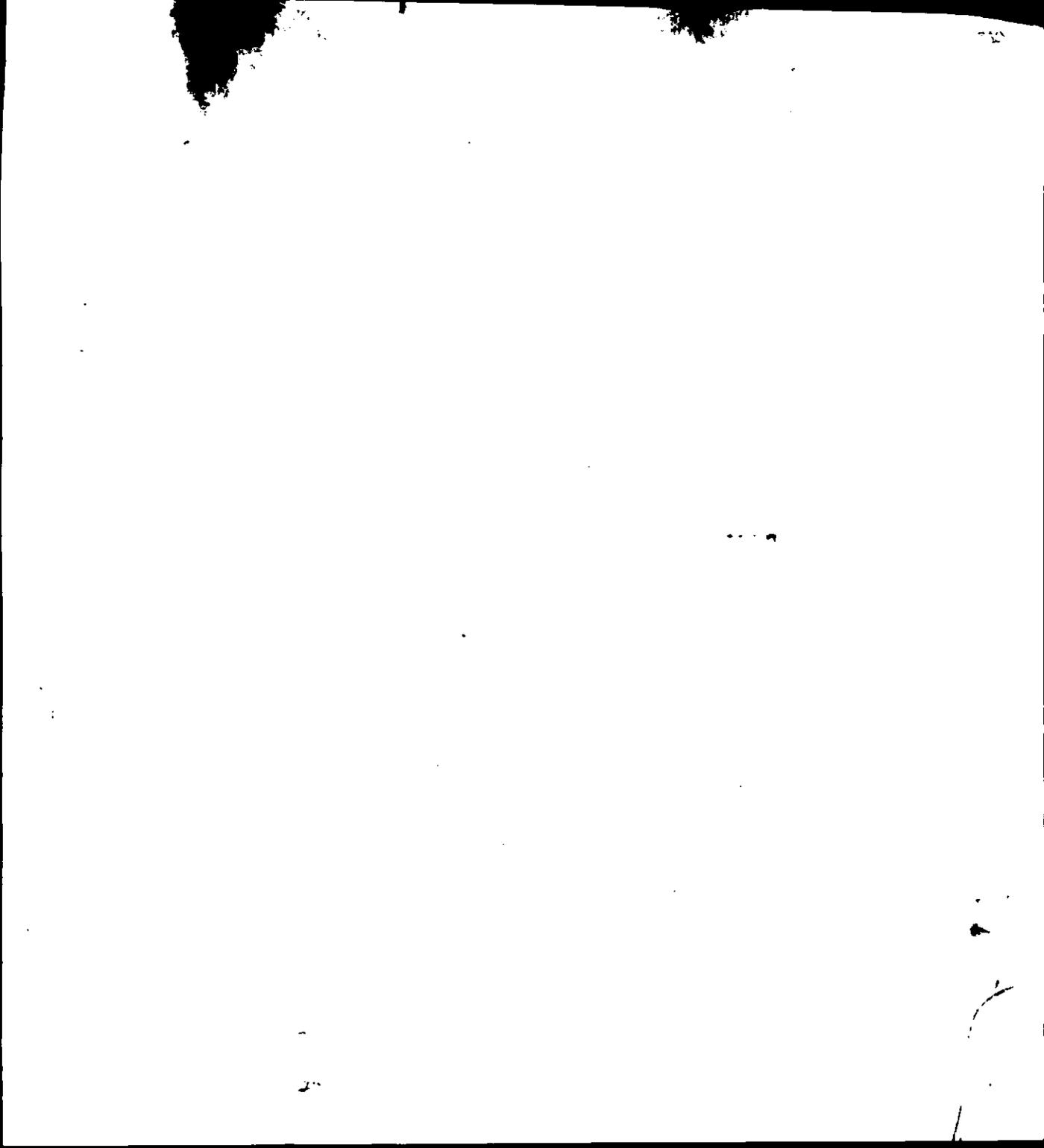
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Wichita Kansas **DATE OF BURIAL** 5-22-1928

20. UNDERTAKER James O'Donnell **ADDRESS** Hannibal

Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be given.

1928



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Marion Registration District No. 5-47 File No.
 Township Primary Registration District No. 3027 Registered No. 131
 City Hannibal (No.) St. Ward

2. FULL NAME

James Beatty
 (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 M 4. COLOR OR RACE B 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (Write the word)

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 5/21 78 Letestree REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-17 1928

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:

Being shot four times by Geo. Wilson was killed by wounds
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) Chas. R. Scott

(Address) Marion 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

20. UNDERTAKER ADDRESS

19

SUPPLEMENTARY

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occasion is very important. REGISTRARS SHALL NOT RECEIVE A FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS BY LAW

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