

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

Do not use this space.

27. PLACE OF DEATH
 County Newton Registration District No. 612
 Township Van Buren Primary Registration District No. 5814
 City..... (No.....)..... St..... Ward.....
2. FULL NAME Helen Catherine Beckull
 (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. 1 mos. 8 ds. How long in U.S., if of foreign birth? yrs. mes. ds.

File No. 24596
 Registered No.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William Beckull
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan-27-1891
7. AGE YEARS 37 MONTHS 0 DAYS 0
 IF LESS than 1 day, hrs. or min.
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) 11
 (c) Name of employer n

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York
10. NAME OF FATHER Martin Kipling
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) N. Y.
12. MAIDEN NAME OF MOTHER Don't Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) N. Y.

14. INFORMANT W. J. W. Beckull
 (Address) Sarevie Mo.
15. FILED Aug 8 1928 U. P. Moody
 REGISTRAR

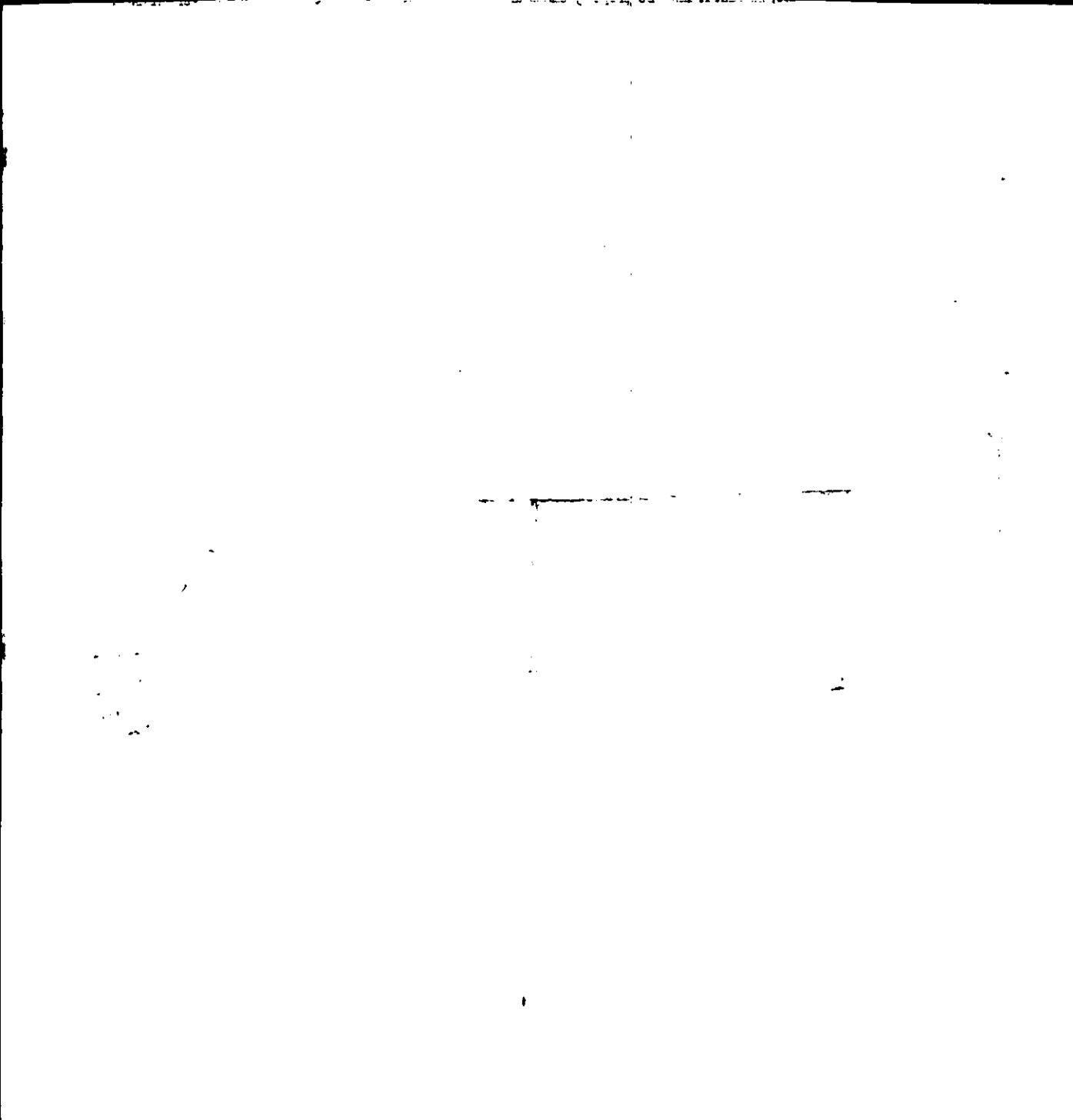
MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 12 1928
17. I HEREBY CERTIFY, That I attended deceased from July 10 1928, to July 12 1928 that I last saw him alive on July 12 1928, and that death occurred, on the date stated above, at 3:00 A. M.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Acute Gastritis
128
125
 (duration) yrs. mes. ds.
CONTRIBUTORY (SECONDARY)
 (duration) yrs. mes. 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) J. W. B. Brough, M. D.
July 13, 1928 (Address) Sarevie Mo.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Sarevie, Tenn. **DATE OF BURIAL** July-14 1928
20. UNDERTAKER Sarevie **ADDRESS** Sarevie



**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 Newton Registration District No. 612 File No.
Township Van Buren Primary Registration District No. 3-814 Registered No.
City (No.) St. Ward

2. FULL NAME

Helen Catharine Campbell

(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 <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>M</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jun 27-1891</u>		
7. AGE YEARS <u>37</u>	MONTHS <u>5</u>	DAYS <u>15</u>
If LESS than 1 day, hrs. or min.		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(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 Aug 8 19 28 C. P. Moody REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 12 19 28

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..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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)....., M. D. , 19 (Address)

*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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

STATED EXACTLY. PHYSICIAN'S NAME OF DEPARTMENT OF HEALTH SHOULD BE STATED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

AGE SHOULD BE STATED. AGE SHOULD BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

BIRTH IN PLAIN TEXT.

SUPPLEMENTARY

S-24596