

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

Do not use this space.

20857

1. PLACE OF DEATH

County Grade
Township North Morgan
City North Morgan (No.)

Registration District No. 11574
Primary Registration District No. 6290

File No.
Registered No. 8
St. Ward)

2. FULL NAME

Ransom Beck

(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 Male 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 Mary Rebecca Beck

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1867.8.16

7. AGE YEARS 41 MONTHS 4 DAYS 29 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Samuel W. Beck

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

12. MAIDEN NAME OF MOTHER Susan Williams

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

14. INFORMANT Samuel J. Beck
(Address) Independence, Mo.

15. FILED Aug 10, 1928 T.H. Brewer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 19

17. I HEREBY CERTIFY That I attended deceased from July 26, 1928, to Aug 19, 1928 that I last saw him alive on Aug 9, 1928, and that death occurred, on the date stated above, at 11 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Unpleasant (Malta) fever

5 14 (duration) yrs. mos. 13 da.

CONTRIBUTORY (SECONDARY) 14 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Septicemic test

(Signed) V.B. Kirby, M. D.

Aug 9, 1928 (Address) Dadeville 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

Long Cem - Aug 10 1928

20. UNDERTAKER ADDRESS

Will Mage Dadeville Mo

Also should be stated that
probably also should be stated that

Also should be stated that
probably also should be stated that

N. B.—Every statement should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in full. That it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NO A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

MISSOURI STATEBOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

8-28
ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Osage
Township North Morgan
City Beck (No.)

Registration District No. 1154
Primary Registration District No. 6990

File No.
Registered No. 8
St. Ward)

2. FULL NAME

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

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) unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) unknown

14.

INFORMANT (Address)

15.

FILED

Aug 19 28

T. H. Brewer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 10 19 28

17.

I HEREBY CERTIFY, That I attended deceased from, 19...., to, 19...., that I last saw him alive on, 19...., and that death occurred, on the date stated above, atm.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

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

S-26867