

FEB 2 1929

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

Do not use this space.
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1. PLACE OF DEATH
 County Darvess Registration District No. 250
 Township Primary Registration District No. 4150
 City Hallatin (No.) St. Ward)

2. FULL NAME Betty June Beaman
 (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) ✓ ✓ ✓

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 8-1928

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
✓ 7 19

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) Hallatin
 (STATE OR COUNTRY) Darvess Co. Mo.

10. NAME OF FATHER Charles F. Beaman

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

12. MAIDEN NAME OF MOTHER Carrie E. Baldwin
 (STATE OR COUNTRY) Illinois

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

14. INFORMANT Chas F. Beaman
 (Address) Hallatin, Mo.

15. FILED 1/28 1929 Ph Gardner
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) January 27 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1929, to Jan 27, 1929 that I last saw h. ex. alive on Jan 26, 1929, and that death occurred, on the date stated above, at 2:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho-Pneumonia
107A
 (duration) yrs. mos. 15 da.

CONTRIBUTORY (SECONDARY) (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. Clinical
 (Signed) M. A. Smith, M. D.
1/28, 1929 (Address) Hallatin 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 Masonic Cemetery, Mo DATE OF BURIAL 1/28 1929

20. UNDERTAKER H. A. Hope ADDRESS Hallatin

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.

REPORT OF DEATH

STATE OF ILLINOIS

**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 Daviess Registration District No. 250 File No. _____
 Township _____ Primary Registration District No. 4150 Registered No. 521
 City Gallatin (No. _____) St. _____ Ward _____

2. FULL NAME Betty June Beaman

(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (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 1/28, 1929 Ph. Gardner
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 27, 1929 19

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Broncho-Pneumonia
Measles or Whooping Cough = No =
 (duration) _____ yrs. _____ mos. _____ da.
 CONTRIBUTORY (SECONDARY) 100%
 (duration) _____ yrs. _____ mos. _____ da.

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

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

SUPPLEMENTARY

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