

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

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3090

1. PLACE OF DEATH

County Randolph Registration District No. 735
 Township Moberly Primary Registration District No. 3034
 City Moberly (No. 731 So Clark)
 Registered No. 20 St. _____ Ward _____

2. FULL NAME

Wallace A. Beacom
 (a) Residence. No. 731 So Clark 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>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>✓</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
✓

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 6th 1927

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	1	5	21	

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER Wendall Beacom

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

12. MAIDEN NAME OF MOTHER Maie Caplinger

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

14. INFORMANT Wendall C Beacom
 (Address) Moberly, Mo.

15. FILED 1/29, 27 Dr. Wood Fleming
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1929 to Jan 27 1929
 that I last saw him alive on Jan 27 1929, and that death occurred, on the date stated above, at 2:10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia

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

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

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

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) C. R. Hester, M. D.
1-29, 1929 (Address) Moberly 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 Moberly Mo DATE OF BURIAL Jan 29 1929

20. UNDERTAKER Mahon Son ADDRESS Moberly Mo

CAUSE OF DEATH to be filled in by physician. Exact statement of Cause of Death should be fully supplied. AGE should be properly classified. Exact statement of Occupation should be fully supplied.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in full terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATE'S UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH.

County Randolph Registration District No. 735- File No. _____
 Township _____ Primary Registration District No. 2134 Registered No. 20
 City Moberly (No. _____) St. _____ Ward _____

2. FULL NAME Wallace A Benson

(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 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.
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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 3/23, 1929 Dr. Thos. S. Fleming
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchitis pneumonia

CONTRIBUTORY Whooping Cough (duration) _____ mos. da.
 (SECONDARY) (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) R. H. Hester, M. D.
 , 19____ (Address) Moberly 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 _____

SUPPLEMENTARY

S-309D