

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

Do not use this space.

5848

**1. PLACE OF DEATH**

County Clay Registration District No. 198 File No. \_\_\_\_\_  
 Township Truman Primary Registration District No. 3071 Registered No. 20  
 City Excelsior Spring (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Beverly Wynon Fueltz

(a) Residence. No. 710 Summit 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) child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 18 - 1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 18 hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work child  
 (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) Excelsior Spring Mo

10. NAME OF FATHER Ernest Fueltz

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

12. MAIDEN NAME OF MOTHER Minnie Bryan

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

14. INFORMANT Ernest Fueltz  
 (Address) Excelsior Springs Mo.

15. FILED 2/19 24 19 24 Y.P. Craven REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

17. I HEREBY CERTIFY That I attended deceased from Feb 18, 1929 to Feb 19, 1929 that I last saw her alive on Feb 19, 1929, and that death occurred, on the date stated above, at 12:30 P.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS: 1**

Craniosacral block  
of vertebrae foramina  
of vertebral column at birth

**CONTRIBUTORY (SECONDARY)**

Boon blue baby  
1500

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

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical  
 (Signed) G.P. Craven M.D.  
 \_\_\_\_\_, 19 \_\_\_\_\_ (Address) Exc. Spgs. 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 \_\_\_\_\_

Salem Feb 20 1929  
 20. UNDERTAKER Herbert Hope ADDRESS Excelsior Spring Mo

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.

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