

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

Do not use this space.

5360

**1. PLACE OF DEATH**

County Jasper  
Township Jackson  
City Cartersville (No. ....)

Registration District No. 408  
Primary Registration District No. 5563A

File No. ....  
Registered No. ....  
St. .... Ward)

**2. FULL NAME**

Josie Beck

(a) Residence No. .... St. .... Ward. ....  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown to us

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 17 - 1862

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	<u>68</u>	<u>4</u>	<u>6</u>	

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Arkansas  
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>J. Hayes</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Texas</u>
	12. MAIDEN NAME OF MOTHER <u>Katie Paine</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Arkansas</u>

14. INFORMANT Jud Howell  
(Address)

15. Feb 28, 1930 E. H. Tetchum  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) February 23 - 1930

17. I HEREBY CERTIFY, That I attended deceased from 2-10, 1930, to 2-29-30, 1930, that I last saw him alive on 2-21-30, 1930, and that death occurred, on the date stated above, at 4 oc a.m.

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

Chronic Brights

CONTRIBUTORY (SECONDARY) 131  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 1290  
IF NOT AT PLACE OF DEATH..... (duration) yrs. mos. ds.

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) J. E. Baker, M. D.  
, 19 (Address) Cartersville 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 <u>Cartersville Mo</u>	DATE OF BURIAL <u>2-24 1930</u>
---	---------------------------------

20. UNDERTAKER <u>Webb City Undertaking Co.</u>	ADDRESS <u>Webb City</u>
---	--------------------------

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.

MAR 27 1930

STANDARD ENGLISH  
INSTRUCTION

STANDARD ENGLISH INSTRUCTION  
INSTRUCTION

**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 Jasper Registration District No. 408 File No. ....  
Township E Jackson Primary Registration District No. 3363 Registered No. ....  
City (No. ....) St. .... Ward .....

**2. FULL NAME**

Jessie 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 17-1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
X 67 X 4 6

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (duration) ..... yrs. .... mos. .... da.  
(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 4/9/30 E.H. Schaw  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 23 1930

17. I HEREBY CERTIFY, That I attended deceased from ..... to ..... 19....., 19....., and 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. .... 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**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.  
 DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.  
 PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be carefully supplied.  
 G. S. S. SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-5360