APR 30 1930

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

Do not use this space.

9826

1. PLACE OF DEATH
County Phelps
Township Miller
City ..... (No. ....., ... St. ..... Ward)

Registration District No. 677
Primary Registration District No. 5903

File No. -7..
Registered No. .....

2. FULL NAME Wilhem Beckman

(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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11-30-1867

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	62	3	17	

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) .....
(STATE OR COUNTRY) Germany

PARENTS
10. NAME OF FATHER John D Beckman
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Henry Jetie Berling
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

14. INFORMANT Nettie Beckman
(Address) Dixon Mo

15. FILED ....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/17 1930

17. I HEREBY CERTIFY, That I attended deceased from Mar 11, 1930 to Mar 17, 1930 that I last saw him alive on March 17, 1930, and that death occurred, on the date stated above, at 7.30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Labor Pneumonia
11A
10S
(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (SECONDARY) Influenza
(duration) ..... yrs. ..... mos. 7 ds.

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) A. J. Crider, M. D.
, 19 (Address) Dixon 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
Ramsey Country	3/19 1930

20. UNDERTAKER	ADDRESS
Fred H Gilbert	Dixon 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.