

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

Do not use this space.

19153

1. PLACE OF DEATH

County Springfield

Registration District No. 318

Township Springfield

Primary Registration District No. 2001

City Springfield

(No. Springfield Baptist Hospital)

File No. _____

Registered No. 454

St. _____ Ward) _____

2. FULL NAME

Carlson C. Beck

(a) Residence, No. _____ Ward _____
(Usual place of abode) Marshfield Mo

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Lola M. Beck

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

Apr 25, 1876

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>54</u>	<u>1</u>	<u>17</u>	

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)

Irma

(STATE OR COUNTRY)

10. NAME OF FATHER

Frank Beck

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

England

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Mary Hughes

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

D. lauer

(STATE OR COUNTRY)

14. INFORMANT

R. H. Beck

Address 806 W. Rogers Springfield, Mo

15. FILED 6-12-30 1930 For Sharp REGISTRAR

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

June 12 1930

17. I HEREBY CERTIFY, That I attended deceased from June 10, 1930, to June 12, 1930. That I last saw him alive on June 12, 1930, and that death occurred, on the date stated above, at 10-25 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis
Uremia (duration) 1-2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Uremia (duration) yrs. mos. ds. 2

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) Koover Gysin, M. D.

6/12-30 (Address) Springfield, 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

Marshfield Mo

DATE OF BURIAL

6/13 1930

20. UNDERTAKER

H. J. Mahan

ADDRESS

Marshfield

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS SHOULD STATE AND SHOULD BE SATED EXACTLY. PHYSICIANS SHOULD STATE AND SHOULD BE SATED EXACTLY.

61-22-1234

