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

Do not use this space.

26480

1. PLACE OF DEATH
County Harrison — Registration District No. 334 — File No. 413
Township Cypress — Primary Registration District No. 5481 — Registered No.
City ..... (No. ..... St. ..... Ward)

2. FULL NAME Martha A Beals
(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 F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OR~~ (OR) WIFE OF Wm. Beals D.E.C.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-1-1848

7. AGE — YEARS — MONTHS ✓ — DAYS — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House 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) Mo.

PARENTS
10. NAME OF FATHER Ruben P Mooney
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Do not know
12. MAIDEN NAME OF MOTHER Nancy Johnson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Do not know

14. INFORMANT W. T. Beals
(Address) Bethany Mo

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-8- 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 5, 1930, to Aug 8, 1930 that I last saw her alive on Aug 8, 1930, and that death occurred, on the date stated above, at 3:00 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis
(duration) yrs. 4 mos. ds.
CONTRIBUTORY (SECONDARY) Hypostatic pneumonia
(duration) yrs. mos. 3 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. L. Wessing, M. D
8-10, 1930 (Address) Bethany 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 Salmon Cemetery — DATE OF BURIAL 8-10 1930

20. UNDERTAKER S M Haas — ADDRESS Bethany 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.

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 Harrison Registration District No. 334 File No.

Township Cypress Primary Registration District No. 3481 Registered No. 413

City (No. St. Ward)

2. FULL NAME Martha A. Beals

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

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 F

4. COLOR OR RACE W

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July-1-1848

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
82	1	7	

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)

PARENTS

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 8/10, 1930. W J Harned
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 8 1930

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

(duration) yrs. mos. ds.

CONTRIBUTORY
(SECONDARY)

(duration) yrs. mos. 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) , 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

SUPPLEMENTARY

N. B.—Every [illegible] should be carefully supplied. [illegible] state CAUSE OF DEATH [illegible] so that it may be properly classified. [illegible] OCCUPATION [illegible] important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNLESS [illegible] COMPLETE AS PRESCRIBED BY LAW

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