

UCL 22 1030

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

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1. PLACE OF DEATH

County Howell
Township Dry Creek
City (No. _____) _____

Registration District No. 387
Primary Registration District No. 5540

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Mrs Artemisia Beckley

(a) Residence. No. _____ St. _____ Ward _____
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 72 11 16

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Bethany, Mo. (STATE OR COUNTRY)

10. NAME OF FATHER Mr. F. Lemmings

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) _____

14. INFORMANT E.W. Beckley (Address) Pomona, Mo

15. FILED 11/24 1930 Mattie O. Kramer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 21 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 21, 1930, to _____, 19____, that I last saw her alive on Nov 21, 1930, and that death occurred, on the date stated above, at 9:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute indigestion

1145 (duration) yrs. mos. ds. 1930

CONTRIBUTORY (SECONDARY) Infected tip 13 months before (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) F.M. Scoble M. D. .19 (Address) Pomona 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 Mount Zion DATE OF BURIAL Nov-28 1930

20. UNDERTAKER R.R. Burns ADDRESS Williamstown Mo

N. R. - Be sure to state in plain terms, so that it may be properly classified. - Statement of UCL 22 1030 is very important.

[The main body of the document is extremely faint and illegible, appearing to be a form with multiple columns and rows of text.]



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

FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Dowell Registration District No. 387 File No. _____
 Township Dry Creek Primary Registration District No. 5540 Registered No. 1
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Artemicia Beckley

(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** M
(write the word)

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>72</u>	<u>11</u>	<u>16</u>	

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 21 19 37

17. I HEREBY CERTIFY That I attended deceased from _____, 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:
with Indigestion
Don't know

On this certificate the informant has left this location and I am unable to get in touch with him. If he returns I will get same and send it.

(duration) yrs. mos. ds.
Injured hip
Don't know
 (duration) yrs. mos. ds.
 DEATH DATE OF DEATH _____ DATE OF _____
 DIAGNOSIS _____ M. D. 29

15. (Address) 1/2 - 131 Motter St. St. Louis, Mo.

20. UNDERTAKER _____ **DATE OF BURIAL** _____

REGISTRAR _____ **ADDRESS** _____

WHITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

REGISTRARS SHALL REGISTER UNTIL THEY ARE COMPLETE AS PRESCRIBED-B/LAW
 N. B. - Every death certificate should be carefully checked. If any errors are found, the informant should be notified. If the informant is unable to be reached, the registrar should be notified. If the informant is unable to be reached, the registrar should be notified. If the informant is unable to be reached, the registrar should be notified.

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