

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

Do not use this space.

799 *Dr. Dewey*

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

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.

1. PLACE OF DEATH
 39 County: *Greene* Registration District No. *318*
 Township: *11* Primary Registration District No. *D 07439*
 City: *Springfield, Mo. Rt. 11 - Michale St Road* St. *34* Ward *34*

2. FULL NAME *Mad. Josephine Beyer*
 (a) Residence. No. *Rt. 11 - Michale St. Rd.* St. *34* Ward *34*
 (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 *Female*
 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 *H. A. Beyer*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct. 28 - 1877*
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
54 | 2 | 12 | - | -
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Home 2nd*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer
 9. BIRTHPLACE (CITY OR TOWN) *Olney* (STATE OR COUNTRY) *Illinois*
 PARENTS
 10. NAME OF FATHER *Unknown*
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*
 12. MAIDEN NAME OF MOTHER *Unknown*
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*
 14. INFORMANT *Mrs. H. A. Beyer* (Address) *Rt. 11 -*
 15. FILED *1-12-1932* *Lon Sharp* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2
 16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 10 - 1932*
 I HEREBY CERTIFY, That I attended deceased from *Jan 7* 19*32* to *Jan 10* 19*32*
 that I last saw her alive on *Jan 7* 19*32*, and that death occurred, on the date stated above, at *2 P.* m.
 THE CAUSE OF DEATH WAS AS FOLLOWS:
Myocardial insufficiency
112
73.8 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) *Bronchial Asthma*
 (duration) yrs. mos. ds.
 18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH? *No* DATE OF *(D)*
 WAS THERE AN AUTOPSY? *No*
 WHAT TEST CONFIRMED DIAGNOSIS? *clinical*
 (Signed) *James B. Dewey* M. D.
 19 (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 DATE OF BURIAL
East Lawn *Jan 12 1932*
 20. UNDERTAKER *Alma La Meyer* ADDRESS *534 St Louis St.*
Funeral Home

FEB 24 1932

201