

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

Do not use this space.

31710
M-9

1. PLACE OF DEATH

10 County Cedar
Township Clinton
City _____

Registration District No. 164
Primary Registration District No. 5229

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

2. FULL NAME

Theodore Reed Beard

(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

Male

4. COLOR OR RACE

White

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

Single

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

Single

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

June 23-1905

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

27

3

23

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)

Cedar Co

(STATE OR COUNTRY)

Mo.

10. NAME OF FATHER

David Beard

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Monticello

(STATE OR COUNTRY)

Ill.

12. MAIDEN NAME OF MOTHER

Ida Beard

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Jordan

(STATE OR COUNTRY)

Kansas

14.

INFORMANT

(Address)

D.C. Beard
Junio Spgs Mo

15.

FILED

Oct 20 1932

F. M. Davis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Oct. 15 - 1932

17.

I HEREBY CERTIFY, That I attended deceased from Oct 15, 1932, to Oct 15, 1932, that I last saw him alive on Oct 15, 1932, and that death occurred, on the date stated above, at 1:55 am m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Typhoid Fever

(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) H. A. Sumrell, M. D.

10-15-1932 (Address) Stockton 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

Hall Cemetery

Oct. 16 1932

20. UNDERTAKER

ADDRESS

O. Mitchell

Junio Spgs 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.

NOV 22 1932

