

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

Do not use this space.

34661

1. PLACE OF DEATH *Audrain Hospital*
 County *Audrain* Registration District No. *26*
 Township *Salt River* Primary Registration District No. *3002*
 City *Maryes Mo.*

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

2. FULL NAME *Agnes J. Beeblecker*
 (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. *1* mos. *0* ds. How long in U. S., if of foreign birth? yrs. *0* mos. *0* ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F.* 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 *Paul Beeblecker*

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1	
				day	hrs. or min.
	<i>86</i>				

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

10. NAME OF FATHER *Jim Beeblecker*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Lawville Mo*

12. MAIDEN NAME OF MOTHER *Fannie Sherman*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Wasson Mo*

14. INFORMANT *Paul Beeblecker*
 (Address) *New Florence Mo*

15. *Nov 26, 1932* *Ira S Milligan*
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *11-25-1932*

17. I HEREBY CERTIFY, That I attended deceased from *10-31-1932* to *11-25-1932*
 that I last saw him alive on *11-23-1932*, and that death occurred, on the date stated above, at *11-25-1932* p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Endocarditis, stenosis of both pulmonary aortic valves, had endocarditis for 14 yrs
57% (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) *gouty rheumatism*
92% (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *Mo*

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Chemical*

(Signed) *Paul E Coy*, M. D.
 , 19 *1932* (Address) *Maryes, 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 *New Florence Cemetery* DATE OF BURIAL *11/27 1932*

20. UNDERTAKER *Paul Bush New Florence 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.

STATE HEALTH DEPARTMENT, WITH CHARGING PARTIAL THIS IS A PERMANENT RECORD

11
4
1932

200

100