

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

22086  
Do not use this space.

REC'D JUL 19 1939

1. PLACE OF DEATH

(a) County Pike Registration District No. 687  
 (b) Township Prairieville Primary Registration District No. 5915  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Edward Beall

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF <u>Hester Beall</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>June 30<sup>th</sup> 1864</u>		
7. AGE	YEARS <u>74</u>	MONTHS <u>11</u>
	DAYS <u>10</u>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	
	11. Total time (years) spent in this occupation	
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Eolia Mo</u>	
	13. NAME <u>Alfred Beall</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>M.S.</u>	
MOTHER	15. MAIDEN NAME <u>Martha Read</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>M.S.</u>	
	17. INFORMANT (ADDRESS) <u>Margarett Beall</u> <u>Eolia Mo.</u>	
	18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Eolia Cemetery June 11-1939</u>	
	19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Good &amp; Edwards Co</u> <u>Eolia Mo.</u>	
	20. FILE <u>June 10, 1939 - B. M. Gooch</u> <u>Local Registrar.</u>	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 10, 1939

22. I HEREBY CERTIFY That I attended deceased from June 10, 1939, to June 10, 1939  
 I last saw him alive on June 10, 1939 Death is said to have occurred on the date stated above, at 6:30 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Cerebral Hemorrhage Date of onset

Other contributory causes of importance: g.j.w.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify \_\_\_\_\_ (Signed) L. P. Guey, M. D.  
 (Address) Eolia Mo.

RECEIVED

District Health Officer No. 10

District File Number 7-39-1165

Date Filed JUL 8 1979

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,         ,  
        , Registered Apprentice No.         ,  
working under my personal supervision.

Signed Norman E. Gooch

Licensed Embalmer No. 2342

P. O. Address Esolia, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.