

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

28595
Do not use this space.

SEP 12 1939

1. PLACE OF DEATH **Buchanan** 3
 (a) County **Buchanan** 1 Registration District No. **85**
 (b) Township " Primary Registration District No. **1001** Registered No. **824**
 (c) City **St Joseph, Mo.** (d) Street No. **State Hospital No. 2** St.
 (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. **2** mos. **17** ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **MARY BEARD**
 (a) Residence, No. **320 N. Main St** St. **Excelsior Springs, Mo.**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED **Married**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **H. D. Beard**
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **1861 ?**
 7. AGE YEARS **78 ?** MONTHS DAYS If LESS than 1 day,hrs. ormin.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **None**
 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
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **? ?**
 FATHER 13. NAME **? ?**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **? ?**
 MOTHER 15. MAIDEN NAME **? ?**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **? ?**
 17. INFORMANT **Hospital Records**
 (ADDRESS) **St Joseph, Mo.**
 18. BURIAL, CREMATION, OR REMOVAL PLACE **Excelsior Springs** DATE **Aug 8**, 19**39**
 19. FUNERAL DIRECTOR (NAME) **Claude Richard**
 (ADDRESS) **Excelsior Springs, Mo.**
 20. FILED **Aug 8**, 19**39** **W. J. Kestelbach**
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **8-8**, 19**39**
 22. I HEREBY CERTIFY, That I attended deceased from **7-15**, 19**39**, to **8-8**, 19**39**
 I last saw h. ex. alive on **8-8**, 19**39** Death is said to have occurred on the date stated above, at **3:15 p. m.**
 The principal cause of death and related causes of importance were as follows:
Broncho-pneumonia
Chronic purulent bronchitis
 Date of onset **8/5/39**
 Other contributory causes of importance: **Diabetes mellitus** ?
 Name of operation _____ Date of _____
 What test confirmed diagnosis **Autopsy** Was there an autopsy? **Yes**
 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? **No**
 If so, specify _____
 (Signed) **G. H. Banett**, M. D.
 (Address) **St. Joseph, 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.

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,

Was not Embalmed

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed *Claude Pichuel*

Licensed Embalmer No. *27271*

P. O. Address

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.