

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.

RECORDED 22 1939

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

39440
Do not use this space.

1. PLACE OF DEATH

(a) County Dade Registration District No. 240
(b) Township North Sac Primary Registration District No. 5-2-2 Registered No. _____
(c) City Arcola, Mo. (d) Street No. _____ 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. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME James W. Beaty.

(a) Residence, No. Arcola, Mo. St. ☐ (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 Elizabeth Beaty

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 3, 1874.

7. AGE YEARS 65 MONTHS 5 DAYS 17 If LESS than 1 day, hrs. or min.

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. Farmer
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) Texas Co. Mo.

13. NAME Alexander Beaty

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

15. MAIDEN NAME Rachel E. Burton.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Mrs. Elizabeth Beaty.
Arcola, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Hickory Grove. DATE Oct. 23, 1939.

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. W. Ward.
Greenfield, Mo.

20. FILED Oct 2 19 39 W. D. Bricker
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 21. 19 39

22. I HEREBY CERTIFY, That I attended deceased from December 1, 1939, to October 12, 1939

I last saw him alive on _____, 19____. Death is said

to have occurred on the date stated above, at 4 p.m.

The principal cause of death and related causes of importance were as follows:

Pneumonia - Lobar Date of onset Oct 16, 1939

Arteriosclerosis general 19 32

Myocarditis chronic 19 35

Other contributory causes of importance: 198

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? no

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) J. H. Shannon M.D.

316 (Address) Greenfield, Mo.

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,

J. W. Ward

or by

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

Signed

J. W. Ward

Licensed Embalmer No. *2832*

P. O. Address *Greensfield, 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.