

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

2020
Do not use this space.

1. PLACE OF DEATH

(a) County Cedar Registration District No. 165
 (b) Township Jefferson Primary Registration District No. 5230
 (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

(a) Residence, No. John Andrew Beatty, 300
 (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 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 Mrs J. A. Beatty

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 28, 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
79 1 29

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

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

13. NAME Joseph Beatty

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

15. MAIDEN NAME Mary Walker

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

17. INFORMANT (ADDRESS) Mrs J. A. Beatty
Hennsville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Hennsville DATE April 25, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Joseph and Sarah
Hennsville Mo

20. FILED Jan 28 1940 Mrs Minnie Coarleton
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 24, 1939

22. I HEREBY CERTIFY, That I attended deceased from Apr 16, 1939, to Apr 24, 1939

I last saw him alive on Apr 16, 1939. Death is said to have occurred on the date stated above, at 3:28 p.m.

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

Cerebral Paralysis Date of onset 8 days

N.M.D.
 Other contributory causes of importance: HTA

Name of operation none Date of _____
 What test confirmed diagnosis? Clinical 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) R. M. D.
 (Address) Hennsville Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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, or by.....

....., Registered Apprentice No.

working under my personal supervision.

Signed..... *Paul Jewstone*

Licensed Embalmer No. *3990*

P. O. Address..... *Rollins 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.