

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **6455**

Registration District No. **266**

Primary Registration District No. **4164**

Registrar's No. **17**

1. PLACE OF DEATH:

(a) County **Salem**
(b) City or town **Salem**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **740**
(Specify whether
In this community **740**
years, months or days)

8. (a) PRINT FULL NAME **MARION L. Beezley**

8. (b) If veteran, **—** 3. (c) Social Security No. **—**
name war **—**

4. Sex **M.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **M.**
6. (b) Name of husband or wife **Mary Jane Beezley** 6. (c) Age of husband or wife if alive **1858** years
7. Birth date of deceased **Feb 1** (Month) (Day) (Year)

8. AGE: Years **81** Months **8** Days **17** If less than one day
br. min.

9. Birthplace **Crawford Co. Mo.** (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **—**

MOTHER FATHER { 12. Name **Beezley**
13. Birthplace **unk** (City, town, or county) (State or foreign country)
14. Maiden name **Rachel Ramsey**
15. Birthplace **unk** (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Bert Beezley**
(b) Address **Salem Mo.**

17. (a) **Burial** (b) Date thereof **2-20-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Union, Cem.**

18. (a) Signature of funeral director **Carl Spencer**
(b) Address **Salem Mo.**

19. (a) **Feb 19 1940** (b) **F. B. Butler M.D.**
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Salem**
(c) City or town **0** (If outside city or town limits, write "RURAL")
(d) Street No. **—** (If rural, give location)
(e) If foreign born, how long in U. S. A. **—** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **18**
year **1940** hour **10:00** minute **A.** M.

21. I hereby certify that I attended the deceased from **1/20/40**
19 **3/10/40** to **3/10/40**, 19 **—**;
that I last saw him alive on **2/10/40**, 19 **—**;
and that death occurred on the date and hour stated above.
Immediate cause of death **Myocarditis**

Due to **1728**
Due to **—**

Other conditions **—**
(Include pregnancy within 3 months of death)

Major findings: **—**
Of operations **—**
Of autopsy **—**

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **—**
(b) Date of occurrence **—**
(c) Where did injury occur? **—** (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **—**

While at work? **—** (Specify type of place) (e) Means of injury **—**

23. Signature **B. E. Jeph** (M. D. **—**)
Address **Salem, Mo.** Date signed **2/19/40**

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.

RECEIVED
District Health Officer No. 5,

District No. 1, 340 329

Date Filed 3/2/60

Signed Tom W. McDonald

Licensed Embalmer No. 3806

P. O. Address Salem, 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.