

**FILED MAR 1 - 1940**

Registration District No. **604**

Primary Registration District No. **5802**

Registrar's No.

**I. PLACE OF DEATH:**

(a) County New Madrid  
(b) City or town Rural New Madrid  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2

In this community 7 months & 11 days  
years, months or days

8. (a) PRINT FULL NAME ELZIE JAMES Mc BEATH

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

4. Sex M.F. 5. Color or race Colored 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife LEE Mc BEATH 6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased JULY 3 1939  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
7 11 hr. min.

9. Birthplace NEW MADRID CO No  
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business No

12. Name LEE Mc BEATH

13. Birthplace Mississippi No  
(City, town, or county) (State or foreign country)

14. Maiden name MICKELIE LEWIS

15. Birthplace Mississippi No  
(City, town, or county) (State or foreign country)

16. (a) Informant Lee Mc Beath  
(b) Address New Madrid, R.P. B/164

17. (a) Burial (b) Date thereof Feb. 13 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Land Hill

18. (a) Signature of funeral director Dr. Richards, And Co

(b) Address New Madrid Mo

19. (a) 2/19/1940 (b) Wm O'Garra 533  
(Determined local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County New Madrid

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. 3 miles S.W. of New Madrid  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? No years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb. day 15  
year 1940 hour 5:40 minute 0 M.

21. I hereby certify that I attended the deceased from Feb 8 - 14  
to Feb 9, 1940

that I last saw him alive on Feb 9 - 40, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Duration  
3 1/2

Due to

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 G N Wilson (M. D. or other)

Address Lilbourn Date signed 2-16-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

72

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**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.....

Licensed Embalmer No.....

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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 7533

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 604

Primary Registration District No. 3802

Registrar's No.

1. PLACE OF DEATH

(a) County New Madrid  
(b) City or town New Madrid rural  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Elzie James McBeath

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if  
alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
2 11 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(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.

20. DATE OF DEATH Month 2 day 15  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
that I have seen him \_\_\_\_\_ alive on \_\_\_\_\_  
and that death occurred on the date and hour stated above.

ImmEDIATE CAUSE OF DEATH pneumonia lobes  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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) Means of injury \_\_\_\_\_

23. Signature G. J. Wilson (M. D. or other)  
Address Fillbourn Date signed \_\_\_\_\_

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

