

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10793

Registration District No. 243 Primary Registration District No. 5337 Registrar's No.

1. PLACE OF DEATH:
(a) County Dallas, Fair Grove, R#1
(b) City or town Rural, Sheridan Twp.
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) 53 yrs, 1 mo, 12 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Dallas
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. RFD No 1 Fair Grove
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

8. (a) PRINT FULL NAME: Brice Beckerdite

8. (b) If veteran, name war none (c) Social Security No. _____

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased: Feb 15 1885
(Month) (Day) (Year)

8. AGE: Years 50 Months 1 Days 12 If less than one day _____ hr. _____ min.

9. Birthplace: RFD #1 Fair Grove Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation: Farmer Retired 20 yrs

MOTHER FATHER { 12. Name: John W. Beckerdite
13. Birthplace: Missouri
14. Maiden name: Sarah J. Bass
15. Birthplace: Missouri

16. (a) Informant: Sarah J. Beckerdite
(b) Address: RFD No 1 Fair Grove

17. (a) Burial (b) Date thereof: March 27 1940
(Barial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Mt Olive

18. (a) Signature of funeral director: [Signature]

(b) Address: Springfield Mo

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 27 year 1940 hour 10:50 minute P M.

21. I hereby certify that I attended the deceased from Jan 10 1929 to March 28 1940 that I last saw him alive on Mar 18 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Paryotomata nephriti
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? _____

(e) Means of injury: _____ (Specify type of place) While at work? _____

23. Signature: E M Bailey (M. D. or other) _____
Address: Falkner Mo Date signed: 3/28/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

30

FILED APR 22 1940

39
38
1492

1221

RECEIVED

District Health Officer No. 7,

District File Number 4-4-611

Date Filed 4-8-40

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.

No Embalming
Signed *Ray Robinson*

Licensed Embalmer No. *1763*

P. O. Address *Springfield*

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. 10793

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 243

Primary Registration District No. 337

Registrar's No. _____

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

1. PLACE OF DEATH: Dallas
 (a) County _____
 (b) City or town Sherridan, Tex.
 (If outside city or town limits, write "RURAL" and name of township)
 (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 Price Beckerdite
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S
 6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

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

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>1</u>	<u>12</u>	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 Mar day 27 year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Parenchymatous Nephritis Duration _____

Due to Chronic

Due to 121

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
 Of operations May 10 1940
 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 E. M. Bagley (M. D. or other) _____
 Address Edmond, Tex. Date signed _____

SUPPLEMENTAL

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10793

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 243

Primary Registration District No. 3337

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Sheridan
(If outside city or town limits, write "RURAL" and name of township)
(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 years, months or days

3. (a) PRINT FULL NAME Price Beckerdite

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married divorced s

6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive year

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

8. AGE: Years 55 Months 1 Days 12 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 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)
(Burial, cremation, or removal)

(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 27
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw h. alive on and that death occurred on the date and hour stated above. Immediate cause of death

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) (e) Means of injury

23. Signature T.M. Bailey
Address Elkland

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY