

JUN 4 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 18664

Registration District No. 400

Primary Registration District No. 55530

Registrar's No. 101

1. PLACE OF DEATH:

(a) County Jackson Prairie Twp  
(b) City or town Lee Summit, R#1  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Woodwill Fresh Air Camp  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2  
(Specify whether

In this community 3 Year  
years, months or days)

3. (a) PRINT FULL NAME John S. Beals 421

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

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

6. (b) Name of husband or wife Sara 6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased Dec 27 1893  
(Month) (Day) (Year)

8. AGE: Years 56 Months 5 Days 21 If less than one day hr. min.

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

10. Usual occupation Care Taker

11. Industry or business Woodwill Camp 9

MOTHER FATHER { 12. Name Joseph Beals

13. Birthplace Don't know  
(City, town, or county) (State or foreign country)

14. Maiden name Oliver Bookout

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

16. (a) Informant Mrs Sara Beals

(b) Address Lee Summit, R#1

17. (a) Burial (b) Date thereof 5/21/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Hill, Mo.

18. (a) Signature of funeral director Carroll Davidson

(b) Address 3024 Trost

19. (a) 5/19/40 (b) Sarah P. Barnes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Lee Summit, R#1  
(If outside city or town limits, write "RURAL")

(d) Street No. R#1  
(If rural, give location)

(e) If foreign born, how long in U. S. A. ✓ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19  
year 1940 hour 9 minute 30 A. M.

21. I hereby certify that I attended the deceased from July, 1939, to May 19, 1940

that I last saw alive on May 18, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Carcinomatosis  
Primary Ca not found

Due to 52

Due to 52

Other conditions 52  
(Include pregnancy within 3 months of death)

Major findings: Generalized Carcinomatosis of abdomen  
Of autopsy 52

PHYSICIAN 52  
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? 939

(e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) [Signature]

Address [Address] Date signed 5-19-40

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

Dr Knight

**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 E. P. Casey

Licensed Embalmer No. 1972

P. O. Address 3024 Troop K.C.M.

**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.

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