DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28367

Registration District No. 2-31 FILED AUG 16 1940 Primary Registration District No. 4144 FILED SEP 19 1940

Registrar's No.

1. PLACE OF DEATH:

(a) County Dade

(b) City or town Greenfield (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Greenfield Mo 2, (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dade

(c) City or town Greenfield (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.

3. (a) PRINT FULL NAME Mrs. D.B. Beard

3. (b) If veteran, name war.

3. (c) Social Security No.

4. Sex Femal

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife D.B. Beard

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Sept. (Month) 4 (Day) 1848 (Year)

8. AGE: Years 96 | Months 10 | Days 26 | If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Lenard Beard
13. Birthplace Tenn. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Tenn. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Family

(b) Address Greenfield Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 1-40 (Month) (Day) (Year)

(c) Place: burial or cremation Pryor Okla

18. (a) Signature of funeral director Harrison & Son Home

(b) Address Greenfield Mo

19. (a) July 31-1940 (Date received local registrar) (b) Ed L Weir (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 30

year 40 hour 9 00 minute P. M.

21. I hereby certify that I attended the deceased from 7-25, 1940 to 7-30, 1940

that I last saw her alive on 7-30, 1940

and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Senility	
Due to	
Due to 1, 2	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature H. O Cowan (M. D. or other)

Address Greenfield Mo Date signed 7-31-40

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should s
CAUSE of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very import

RECEIVED
District Health Officer No. 6,
District File Number 940-2612
Date Filed SEP 17 1940

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.....
Richard E. Cheatham, Registered Apprentice No.....
working under my personal supervision.

Signed Richard E. Cheatham

Licensed Embalmer No. 3813

P. O. Address S. Greenfield, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
2-21-40
X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28367

Registration District No. 227 Primary Registration District No. 4144 Registrar's No.

1. PLACE OF DEATH:
(a) County Dade
(b) City or town Greenfield
(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
If this community (Specify whether years, months or days) Emily Priscilla Beard

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.

3. (a) PLACE OF FUNERAL Mrs. D. B. Beard
3. (b) If veteran, name war
3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 30
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 , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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.

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

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 96 Months 10 Days 26 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

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

19. (a) Oct. 5-40 (Date received local registrar) (b) Geo. L. Wilson (Registrar's signature)

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

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY