

NOV 19 1940

Registration District No. 137

Primary Registration District No. 40-4077

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Hale  
(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 40 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Pauline Elisabeth Beals

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Edwin J. Beals 6. (c) Age of husband or wife if alive Dead years

7. Birth date of deceased September 20, 1851  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

89 0 25 hr. min.

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

10. Usual occupation House wife

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

MOTHER { 12. Name Fredrick Dormois

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

14. Maiden name Caroline Hanna

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

16. (a) Informant Ira Beals

(b) Address chillicothe Missouri

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

(c) Place: burial or cremation Hale Cemetery

18. (a) Signature of funeral director Frank State

(b) Address Hale Mo.

19. (a) 10-17-1940 (b) WPKemp  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll

(c) City or town Hale  
(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 Oct day 15  
year 1940 hour 3 minute 30 P. M.

21. I hereby certify that I attended the deceased from Jan Feb  
1940 to Dec 15, 1940  
that I last saw h. er alive on Oct 13, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death arterio sclerosis

Duration 2 1/2 yr

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Parity Dementia  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? 130 (Specify type of place) \_\_\_\_\_

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

23. Signature WPKemp (M. D. or other) \_\_\_\_\_

Address Hale Mo. Date signed 10-17-40

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

RECEIVED  
District Health Officer No. 8  
District File Number 11-12-40  
Date Filed

**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.....

*Joseph E. Slater*

Licensed Embalmer No.....

*937*

P. O. Address.....

*Hale 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, fact should be so stated above.**