

Registration District No. 241 Primary Registration District No. 5334

1. PLACE OF DEATH:

(a) County Dallas
 (b) City or town Rural S. Benton
 (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 _____
 (Specify whether _____)
 In this community _____
 (years, months or days)

3. (a) PRINT FULL NAME Aaron Ezra Beckner

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 MARRIED6. (b) Name of husband or wife Choke Beckner 6. (c) Age of husband or wife if alive 47 years7. Birth date of deceased Oct 14 1894
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
45 11 27 hr. min.9. Birthplace Dallas Mo.
(City, town, or county) (State or foreign country)10. Usual occupation Farmer 011. Industry or business 012. Name I. M. Beckner13. Birthplace Mo
(City, town, or county) (State or foreign country)14. Maiden name Alice Price
(City, town, or county) (State or foreign country)15. Birthplace Mo
(City, town, or county) (State or foreign country)16. (a) Informant Choke Beckner(b) Address ELKLAND Mo.17. (a) BURIAL (b) Date thereof 10-19-40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Mt Pleasant18. (a) Signature of funeral director L B Jones(b) Address BUFFALO Mo.19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dallas
 (c) City or town RURAL
 (If outside city or town limits, write "RURAL")
 (d) Street No. ELKLAND Mo.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 10
year 1940 hour 6 minute P M.21. I hereby certify that I attended the deceased from Dead when
arrived, 1940, to Oct 10, 1940that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.Immediate cause of death Carcinoma of
Sigmoid 2 1/2 yrs

Due to _____

Due to 46

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations Vido Supra
CalasternOf autopsy None

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?
210

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Elot Hemmer (M. D. or other) 1Address Buffalo Mo Date signed 10-23-40

RECEIVED

District Health Officer No. 7,
District File Number 11-40-1036
11-13-40

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.

Signed Clyde Montgomery

Licensed Embalmer No. ~~3592~~ 3592

P. O. Address Buffalo 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35-160**

Registration District No. **241**

Primary Registration District No. **3334**

Registrar's No. _____

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

1. PLACE OF DEATH:
 (a) County Dallas
 (b) City or town Benton
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 (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 _____ (Specify whether
 In this community _____ years, months or days)

3. (a) PRINT FULL NAME Aaron Ezra Beckner

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 M

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
45 11 27 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) 12-11-40 (b) Raoney Moran
 (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.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Oct day 10
 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.

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

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

