No. 2
4-13-40
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 40908

Registration District No. 791 Primary Registration District No. Registrar's No. 10679

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

1. PLACE OF DEATH:
(a) County
(b) City or town ST. LOUIS ; (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Pacific Hospital. (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 Tennessee (b) County Madison
(c) City or town Jackson (If outside city or town limits, write "RURAL")
(d) Street No. N.R (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME WILLIAM B. BEAL
3. (b) If veteran, name war
3. (c) Social Security No. Unknown.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Hattie
6. (c) Age of husband or wife if alive 58. years
7. Birth date of deceased Sept; (Month) 26th; (Day) 1882. (Year)

8. AGE:	Years	Months	Days	If less than one day
	58	2	28	hr. min.

9. Birthplace Madison County (City, town, or county) Tenn. (State or foreign country)
10. Usual occupation Railroad Brakeman.
11. Industry or business
FATHER
12. Name Kirk Beal
13. Birthplace Unknown. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Mary Ann Parhan.
15. Birthplace Unknown. (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Hattie Beal.
(b) Address Jackson; Tenn.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/26/40. (Month) (Day) (Year)
(c) Place: burial or cremation Decaturville; Tenn.
18. (a) Signature of funeral director Albert H. Hoppe;
(b) Address 4700 Washington Ave.
19. (a) DEC 26 1940 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 24
year 40 hour 6 minute 45 P M.
21. I hereby certify that I attended the deceased from 11-23, 1940, to 12-24, 1940;
that I last saw him alive on 12-24, 1940;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Empyema - Left	
Due to Staphlococcus inf.	
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.

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 A. M. Boyd per K. E. Wilcox (M. D. or other) M.D.'s
Address Mo Pac Hosp St Louis Date signed 12-24-40

(Licensed Embalmer's Statement on Reverse Side)

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 J. G. Sullivan

Licensed Embalmer No. 1122

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.