

Registration District No. 235

Primary Registration District No. 3039

Registrar's No. 7

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

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Moberly
(c) Name of hospital or institution:
414 Harrison St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether
In this community 11 Days
years, months or days)

3. (a) PRINT FULL NAME Beulah Marie Ransdell

8. (b) If veteran, name war None 8. (c) Social Security No. None

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

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

7. Birth date of deceased December, 22, 1940.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 11 hr. min.

9. Birthplace Moberly Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business _____

12. Name Verness Ransdell

13. Birthplace Yates Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Florence Mitchell

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

16. (a) Informant Verness Ransdell

(b) Address 920 Rothwell St. Moberly Mo.

17. (a) Burial (b) Date thereof Jan. 3, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grand Prairie

18. (a) Signature of funeral director Snow Funeral Home
(b) Address Moberly Missouri

19. (a) Jan. 3-41 (b) Seale Williams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
(c) City or town Moberly well St.
(If outside city or town limits, write "RURAL")
(d) Street No. 920 Rothwell St.
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 2nd
year 1941 hour 12 minute 15 P.M.

21. I hereby certify that I attended the deceased from Dec 28 1940 to Jan 2, 1941 that I last saw him alive on Jan 2, 1941 and that death occurred on the date and hour stated above.
Immediate cause of death Pneumonia Duration 5 or 6 days

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy NO

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? _____

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

23. Signature W. P. Meigs (M. D. or other) _____
Address Moberly Mo Date signed 4/3/41

109
RECEIVED

District Health Officer No. 10

District File Number 2-41-413

Date Filed FEB 19 1941

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3985

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 735

Primary Registration District No. 3034

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Moberly
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME

Beverly Marie Ransdell

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7

5. Color or race W

6. (a) Single, widowed, married, divorced 8

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 _____ Months 11 Days _____ If less than one day _____ 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)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

(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 Jan day 2 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia
Medical
Due to no complications

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? _____

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

23. Signature _____ (M. D. or other)

Address _____ Date signed 4/17/14

Duration

47
5
days

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

SUPPLEMENTARY

