

Registration District No. 735 Primary Registration District No. 3034

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Moberly
(c) Name of hospital or institution:
In Ambulance on way to Hospital 3
(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 Wendell Eslie Beacom
(b) If veteran, name war _____
(c) Social Security No. 709-61-285

4. Sex Male () 5. Color or race White
6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife May Beacom
(c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 4th 1892 1907
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>38</u>	<u>9</u>	<u>19</u>	hr. _____ min.

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

10. Usual occupation Painter
11. Industry or business I.C. R.R.

MOTHER FATHER {
12. Name Wallace Beacom
13. Birthplace Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Mayme Maberry
15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. May Beacom
(b) Address Moberly, Mo. Chicago, Ill.

17. (a) Burial (b) Date thereof Mch. 25th, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Moberly, Mo.

18. (a) Signature of funeral director Mahan and Son
(b) Address Moberly

19. (a) Mch 25-41 (b) Leah Williams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Cook
(c) City or town Chicago
(If outside city or town limits, write "RURAL")
(d) Street No. 731 So. Williams St. 3
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 23rd
year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from Mar 20
_____ 1941 to Mar 23 1941
that I last saw him alive on Mar 23 1941
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to Adeno Carcinoma of Duodenum
Due to _____
Other conditions (Include pregnancy within 3 months of death) 46C

Major findings: _____
Of operations _____
Of autopsy yes - above diagnosis determined by 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?
725 (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature C. Smith (M. D. or other) _____
Address Moberly Date signed 4-1-41

Duration Had been complaining for 30 days
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

No. 1-17-

RECEIVED

District Health Officer No. 10

District File Number 4-41-199

Date Filed APR 14 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 Frank DeBitt

Licensed Embalmer No. 3621

P. O. Address Mohely 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.

Registration District No. 735

Primary Registration District No. 3034

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Shelby
(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)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Wendell Estlie Beacon

20. DATE OF DEATH: Month Mar day 23
year 1941 hour _____ minute _____ M.

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

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

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

Immediate cause of death _____

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

7. Birth date of deceased June 4 1902
(Month) (Day) (Year)

8. AGE: Years 38 Months 9 Days 19 If less than one day _____ hr. _____ min.

Duration _____

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

Due to _____

10. Usual occupation _____

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

11. Industry or business _____

Major findings: _____ Of operations _____

12. Name _____

Of autopsy _____

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

14. Maiden name _____ (State or foreign country)

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) 3/25/41 (b) Beak Williams
(Date received local registrar) (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? _____

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

23. Signature C. T. Smith (M. D. or other) _____

Address Shelby Mo Date signed _____

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

11802

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, fact should be so stated above.