

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 24 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

31881

State File No. _____

Registration District No. 1149

Primary Registration District No. 5612

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Laclede
 (b) City or town Lebanon, R.R. Washington Twp
(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 none
(Specify whether)
 In this community 69 years
years, months or days

3. (a) PRINT FULL NAME Della D. Beard

3. (b) If veteran, name war 3. (c) Social Security No. none

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

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

7. Birth date of deceased Sept. 27 1871
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>69</u>	<u>11</u>	<u>7</u>	hr. _____ min.

9. Birthplace Laclede Co. Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Henry Sharp
 13. Birthplace Nashville Tenn.
(City, town, or county) (State or foreign country)
 14. Maiden name Polly Ann Lyman
 15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Henry Beard

(b) Address Lebanon Mo R#1

17. (a) burial (b) Date thereof 9-6-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Cemetery

18. (a) Signature of funeral director W. E. Holman

(b) Address Lebanon Mo

19. (a) 9-6-41 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Laclede 53
 (c) City or town Lebanon Rural Washington Twp
(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

20. DATE OF DEATH: Month Sept. day 4
 year 1941 hour 12 minute 30 AM.

21. I hereby certify that I attended the deceased from Aug 10
1941 to Sept 3 1941
 that I last saw her alive on Sept 3 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death CARDIAC decompensation
Duration

Due to Hypostatic Pneumonia

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? 2

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

23. Signature O. Bohrer (M. D. or other) D.O.

Address LEBANON MO Date signed 9/6/41

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.....

Myself

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Dorsey M Howe*

Licensed Embalmer No. *4222*

P. O. Address *Lebanon 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. 449

Primary Registration District No. 5612

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Lebanon R
(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 Wella W. Beard

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

4. Sex <u>Fr.</u>	5. Color or race <u>W</u>	6. (a) Single, widowed, married, divorced <u>W</u>
6. (b) Name of husband or wife <u>Henry Beard</u>		6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased <u>Sept 27 1874</u> (Month) (Day) (Year)		

8. AGE: Years 64 Months 11 Days _____ (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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) 11-22-41 (Date received local registrar) (b) J. M. Cox (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept year 1941 hour _____ minute _____ M.

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

Immediate cause of death Cardiac decompensation

Due to Hypostatic pneumonia

Due to Non-Bronchial (Lobar)

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

Major findings: _____

Of operations _____

Of autopsy _____

10/8

Duration _____

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? _____

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

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

Address _____ Date signed _____

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

SUPPLEMENTARY

S-31881 - 1941