

No. 2  
1-4-41  
17-39  
X26390

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **35359**

FILLED NOV 13 1941  
Registration District No. **428**

Primary Registration District No. **4281**

Registrar's No. **23**

1. PLACE OF DEATH:

(a) County **Lancaster**  
(b) City or town **Marionville, Mo.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Methodist Home for Aged**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In-hospital or institution **2 1/2 years**  
(Specify whether years, months or days)  
In this community **2 1/2 years, months or days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Charles**  
(c) City or town **Jefferson**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **13th**  
year **1941** hour **11** minute **30** P.M.  
21. I hereby certify that I attended the deceased from **August**  
**4**, 19**41**, to **Oct 13**, 19**41**;  
that I last saw him alive on **Oct 13**, 19**41**;  
and that death occurred on the date and hour stated above.

Immediate cause of death **exhaustion & toxemia several weeks**  
Due to **Red-sores and several weeks**  
**inability to take food**  
Due to **Senility & arteriosclerosis**  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Duration  
Physician  
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME **Emaline Gull Beers**  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex **female**  
5. Color or race **white**  
6. (a) Single, widowed, married, divorced **widowed**  
6. (b) Name of husband or wife **Gardiner B. Beers**  
6. (c) Age of husband or wife if alive **deceased** years \_\_\_\_\_  
7. Birth date of deceased **December 14 1856**  
(Month) (Day) (Year)

8. AGE: Years **84** Months **9** Days **29**  
If less than one day hr. min.

9. Birthplace **Branch Co - Mich!**  
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business \_\_\_\_\_

12. Name **George Gull**

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

14. Maiden name **Catherine Rhodes**

15. Birthplace **Ohio**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Dr. E. G. Beers**

(b) Address **Jefferson - Mo**

17. (a) **Burial** (b) Date thereof **Oct 16 - 41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Jefferson, Mo.**

18. (a) Signature of funeral director **H. H. Kelley**

(b) Address **Jefferson Mo**

19. (a) **Oct 14 1941** (b) **Laura C. Cannady**  
(Date received local registrar) (Registrar's signature)

Major findings:  
Of operations **162**  
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) (e) Means of injury \_\_\_\_\_  
23. Signature **R. P. Lancy** (M. D. or other)  
Address **Marionville, Mo.** Date signed **10/16/41**

414 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 6,

District File Number 1141-1704

Date Filed NOV 10 1911

*Sealed*

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. E. Kellen*

Licensed Embalmer No. *3334*

P. O. Address *Seymour*

**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.**