

DEC 22 1941

Registration District No. 10178

Primary Registration District No. 5195

State File No. _____

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Morgan
 (b) City or town Clawcreek TENN
 (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
 years, months or days)

3. (a) PRINT FULL NAME William Gene Beaver

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

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased July 6 22
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>7</u>	<u>8</u>	<u>5</u>	hr. _____ min.

9. Birthplace St Joseph MO
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Tommie Beaver
 18. Birthplace Marion, Co. Iowa
 (City, town, or county) (State or foreign country)
 14. Maiden name Ida Mae DeForest
 15. Birthplace St Joseph MO
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Tommie Beaver

(b) Address Versailles

17. (a) Versailles (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Versailles

18. (a) Signature of funeral director W F Thibault

(b) Address _____

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Morgan ?
 (c) City or town Rural
 (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. ? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 4,
 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from never
 _____, 19____, to _____, 19____;
 that I last saw him _____ alive on never, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia ✓ Duration 4 days

Due to _____

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?

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

28. Signature P. F. Eckhoff (M. D. or other) D.O.
 Address Versailles, MO Date signed _____

RECEIVED

District Health Officer No. 7,

District File Number 12-41-2049

Case Filed 12-13-41

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.....

Gene Bartram
....., Registered Apprentice No.
working under my personal supervision.

Signed *Gene Bartram*
.....

Licensed Embalmer No. 4021

P. O. Address Urbana, 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38899
Registrar's No.

Registration District No. 476

Primary Registration District No. 6713

1. PLACE OF DEATH:

(a) County Moigan
(b) City or town Lawrence
(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.....

3. (a) PRINT FULL NAME

William J. Beane

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex M.

5. Color of race W

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

6. (b) Name of husband or wife.....

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

7. Birth date of deceased.....

July 6 (Month) 1923 (Day) 1923 (Year)

8. AGE:

Years 7 Months 8 Days 11 (if less than one day) min.

9. Birthplace.....

(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry of 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).....

(Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

St. Louis
Versailles, Mo

(b) Address.....

19. (a).....

(Date received local registrar)

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... day.....
year 1928 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.....
Lobar

Duration

Due to.....

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?

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

23. Signature P. F. Eckhoff, M.D. (Physician or other)
Address Versailles, Mo Date signed 1/8/42

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

SUPPLEMENTARY

S-38899