

Registration District No. **255**

Primary Registration District No. **6245**

1. PLACE OF DEATH:

(a) County **Ripley**
(b) City or town **Gatwood Twp.**
(c) Name of hospital or institution: **3 Mr. East at home Rural**
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Ripley 91**
(c) City or town **Gatwood Twp.**
(d) Street No. **Rural**
(e) Citizen of foreign country? **native** (Yes or No) **0**
If yes, name country _____

3. (a) PRINT FULL NAME **Elsie Acena Beal**

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

4. Sex **Female** 5. Color or race **white**
6. (b) Name of husband or wife **Thos. J. Beal** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Feb. 19 1869**
(Month) (Day) (Year)

8. AGE: Years **73** Months **3** Days **23**
If less than one day _____ hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER
12. Name **Martin Coan**
13. Birthplace **unknown** 9
(City, town, or county) (State or foreign country)
14. Maiden name **unknown** 9
15. Birthplace _____ 9
(City, town, or county) (State or foreign country)

16. (a) Informant **James R. Beal**
(b) Address **# Ponder, Mo.**

17. (a) **Burial** (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Smith Cemetery Ripley Co.**

18. (a) Signature of funeral director **family**
(b) Address _____

19. (a) **6-13-42** (b) **E. O. Johnston**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **June** day **12**
year **1942**, hour **4**, minute **0**, P. M.

21. I hereby certify that I attended the deceased from **June 1 1942** to **June 12 1942**
that I last saw him **June 7 1942** and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Pneumonia** Duration **1 week**

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) **108**

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) (d) Means of injury _____
23. Signature **Clifford G. Porter** (M. D. or other) _____
Address _____ Date signed _____

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

RECEIVED
District Health Officer No. 5,
District File Number 7425-43.
Date Filed 9-11-42.

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.