

FILED JUL 8 1943  
Registration District No. 248

Primary Registration District No. 5843

State File No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Newton  
 (b) City or town Greenwood School Dist.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution St. Mary's Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay In hospital or institution 1 year  
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton  
 (c) City or town Rural (Greenwood)  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 5 mi. dist.  
 (If rural, give location)  
 (e) Citizen of foreign country? 0 (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23  
 year 1943 hour 5 minute 35 P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
 that I last saw her alive on Aug 20 \_\_\_\_\_ 1942  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
 Due to Cerebral Hemorrhage  
 Due to Bonus  
 Other conditions (include pregnancy within 5 months of death) 30

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: Of operations \_\_\_\_\_  
 Of autopsy No

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

23. Signature W. O. P. Bennett (M. D. or other)  
 Address Galena, Kansas Date signed 26/43

3. (a) PRINT FULL NAME MARTHA ANN BEETS

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

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

6. (b) Name of husband or wife deceased 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb. 9 - 1871  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
72 3 14 hr. \_\_\_\_\_ min.

9. Birthplace Phelps Co. Missouri  
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

12. Name Joe Piler

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

14. Maiden name Unknown

15. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)

16. (a) Informant C. F. Beets

(b) Address Lawell, Kansas

17. (a) Removal (b) Date thereof 5/23/43  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lawell Cem. Lawell, Mo

18. (a) Signature of funeral director Bone Ind. Co.

(b) Address Galena, Kansas

19. (a) 1573 (b) W. O. P. Bennett  
 (Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

1310

(Licensed Embalmer's Statement on Reverse Side)

Date Received JUL 6 1943  
File no. 743-126

JUL 7 1943

**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 *Rex N. Shewmake*  
*Kansas* → Licensed Embalmer No. *1998*  
P. O. Address *Galena, Kansas*

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 248 Primary Registration District No. 5843 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Newton  
(b) City or town 5 mile 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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days (Specify whether \_\_\_\_\_)  
3. (a) PRINT FULL NAME Martha Ann Beek  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race D 6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year  
7. Birth date of deceased: Feb 9 (Month) (Day) (Year)

8. AGE: Years 72 Months 3 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)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) 6-1-43 (b) W. R. Bennett  
(Date received local registrar) (Registrar's signature)

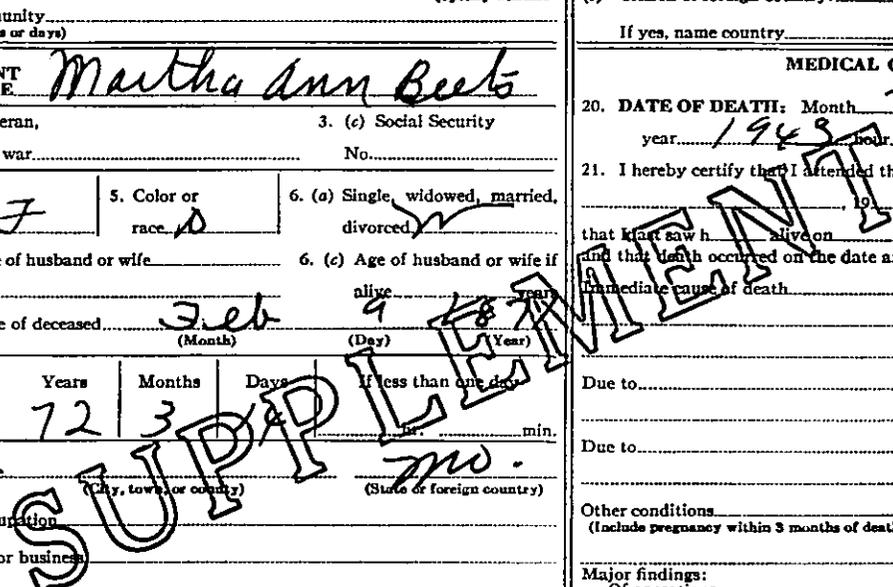
2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Newton  
(c) City or town 5 mile Twp  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Mar year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above, immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.



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

S-22057