

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

FILED AUG 5 1943 42  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan  
 (b) City or town St Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Missouri Methodist Hosp.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 5 weeks  
(Specify whether)  
 In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
 (c) City or town Rural St Joseph  
(If outside city or town limits, write "RURAL")  
 (d) Street No. Route 1 Beck Road  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William Monrow Beckett

3. (b) If veteran, name war No 3. (c) Social Security No. 499-16-4442

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

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

7. Birth date of deceased March 17 1858  
(Month) (Day) (Year)

8. AGE: Years 85 Months 3 Days 9 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Supt. Mt Auburn Cemetery

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

12. Name Robert T. Beckett

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

14. Maiden name Elizabeth Daugherty

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

16. (a) Informant Mrs Evelyn B. Moore

(b) Address St Joseph, Mo.

17. (a) Burial (b) Date thereof 6-29-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Auburn Cemetery

18. (a) Signature of funeral director Fleeman & Son Inc.

(b) Address 1946 Colhoun St.

19. (a) 6-29-43 (b) W. S. Herzog  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26th  
 year 1943 hour 7 minute P.M.

21. I hereby certify that I attended the deceased from May 20, 1943, to June 26, 1943  
 that I last saw him alive on June 26, 1943  
 and that death occurred on the day and hour stated above.

Immediate cause of death:  
Mycobacterium tuberculosis  
Respiratory tract infection  
 Due to with pleural  
Septicemia bacteremia  
 Due to ulcers - sacrum  
Practiced rt. hip  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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? 131

While at work? \_\_\_\_\_ (Specify type of place)  
 (c) Means of injury: 1

23. Signature W. S. Herzog (M. D. or other) \_\_\_\_\_  
 Address St Joseph Mo Date signed 6-28-43

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 Robert H. Gypke

Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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. 42 Primary Registration District No. 10008

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town St Joseph  
(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 Wm Monroe Bechelt  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June 26  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_ - \_\_\_\_\_ 19\_\_;  
that I have seen him/her alive on \_\_\_\_\_ 19\_\_;  
and that death occurred on the date and hour stated above.

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

Immediate cause of death myocarditis  
angiosclerosis  
heart failure  
Duration \_\_\_\_\_

7. Birth date of deceased: mar 17 ind  
(Month) (Day) (Year)

Due to Septicemia decompen-  
situm  
ultra solum  
Disseminated fracture of hip 5/19

8. AGE: Years 46 Months 2 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

Major findings: 1860  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

10. Usual occupation \_\_\_\_\_

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

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

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_ (State or foreign country)

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) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) accident  
(b) Date of occurrence 5-20-43  
(c) Where did injury occur? St Joseph, Buchanan Mo (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
home  
While at work? no (Specify type of place) (e) Means of injury fall from over  
23. Signature W. D. Conner (M. D. or other)  
Address 722 E. Main St. South Mo Date signed 8-9-43

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

SUPPLEMENTARY

MOTHER FATHER

9.

S-24327