

FILED DEC 23 1943

Registration District No. _____

Primary Registration District No. 5219

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

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Rural Campbell Branch
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 1
(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 MO (b) County Cass
(c) City or town Rural Campbell Branch
(If outside city or town limits, write "RURAL")
(d) Street No. 11 mi S.E Pleasant Field
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 18th
year 1943 hour 10 minute 35 A. M.
21. I hereby certify that I attended the deceased from Dec. 16 1943 to Dec. 18 1943
that I last saw him alive on Dec. 18 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Duration 24 hrs.

Due to Apoplexy 2 days.

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 _____

23. Signature Dr. C. Bennett (M.D. or other) D.O.
Address Harrisonville, Mo. Date signed 12-20-43

3. (a) PRINT FULL NAME Walter Bell McBeue

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 Married

6. (b) Name of husband or wife Laura May McBeue 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased Feb 12 - 1878
(Month) (Day) (Year)

8. AGE: Years 65 Months 10 Days 17 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Charles McBeue

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

14. Maiden name Emily West

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

16. (a) Informant Jack McBeue

(b) Address Harrisonville MO

17. (a) Burial (b) Date thereof Dec 20 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Andrew MO

18. (a) Signature of funeral director RUNNENBURGER'S
(b) Address HARRISONVILLE, MO.

19. (a) Dec. 20, 1943 (b) Margaret Valle
(Date received local registrar) (Registrar's signature)

MAY 14 1954

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

Ernest Rumbarger

Licensed Embalmer No.

3368

P. O. Address

Harrisonville

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

JAN

Registration District No. 59

Primary Registration District No. 5219

Registrar's No. 207

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Rural Camp Branch
(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 Walter Bell McCune

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

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

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

7. Birth date of deceased Feb. 1 (Month) (Day) (Year)

8. AGE: Years 65 Months 10 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or 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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Year 1943 Day 8 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death Uremia Chronic

Due to apoplexy

Other conditions _____ (include pregnancy within 3 months of death)

Major findings: _____

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) Means of injury _____

23. Signature Dr. C. E. Everett (M. D. or other) DO

Address Harrisonville, Mo Date signed 1-1-44

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

SUPPLEMENTARY

Duration 2 wks
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

5-41924