

S. No. 2
M-5-43
v. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9687

State File No. _____

1497

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
2740 Cleveland Street
(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) 65 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City Missouri
(If outside city or town limits, write "RURAL")

(d) Street No. 2740 Cleveland Street
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mrs Mary A. BECK

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29th
year 1944 hour 10:45 minute _____ P.M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife James Wesley Beck

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

7. Birth date of deceased May 4th 1857
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1934
_____ 19____ to _____ 19____
that I last saw him _____ alive on Feb _____ 1944
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>86</u>	<u>10</u>	<u>25</u>	hr. _____ min.

Immediate cause of death Ch. myocarditis

Due to _____

Due to _____

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

10. Usual occupation Housewife

11. Industry or business At Home

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

Major findings:
Of operations _____

Of autopsy _____

MOTHER FATHER

12. Name Phillip Barrett

13. Birthplace County Mayo Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Mary Salven

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs J. F. Sanstra

(b) Address 2740 Cleveland Street

17. (a) Removal (b) Date thereof 3-31-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chapman, Kansas

18. (a) Signature of funeral director Melody-McGilley

(b) Address Kansas City Missouri

19. (a) 3-30-44 (b) P. E. Brown
(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) _____

(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 Wm R. Jackson (M. D. or other) _____

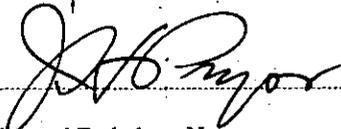
Address 1147 Broadway _____

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.