

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
FILED MAY 9 1944THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14289

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 146

1. PLACE OF DEATH:

(a) County CALLAWAY
 (b) City or town FULTON
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
CALLAWAY COUNTY HOSPITAL 0
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 DAYS.
 (Specify whether
 In this community 80 YEARS
 years, months or days)

3. (a) PRINT FULL NAME VIRGINIA LEE BEATTY

3. (b) If veteran, name war: No
 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced, WIDOWED

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

7. Birth date of deceased: MAY 17 1863
 (Month) (Day) (Year)

8. AGE: Years Months Days
80 11 6
 If less than one day hr. min.

9. Birthplace CALLAWAY COUNTY MISSOURI
 (City, town, or county) (State or foreign country)

10. Usual occupation AT HOME11. Industry or business SAME12. Name LAFAYETTE LINDSEY

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

14. Maiden name UNKNOWN

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

16. (a) Informant A. S. Jarnay

(b) Address FULTON RT-2

17. (a) BURIAL (b) Date thereof 4-25-44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HILLCREST CEMETERY18. (a) Signature of funeral director WALLACE FUNERAL HOME(b) Address FULTON, Mo.

19. (a) 4-25-1944 (b) Joan Moravichoff
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CALLAWAY Co
 (c) City or town FULTON
 (If outside city or town limits, write "RURAL")
 (d) Street No. R. F. D # 2
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23rd
 year 1944 hour 11:15 minute 0 P. M.

21. I hereby certify that I attended the deceased from Apr 12, 1944, to Apr 23, 1944
 that I last saw him alive on Apr 22, 1944,
 and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Atrophia Senilis
 Due to old age

Other conditions (Include pregnancy within 3 months of death) 97

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

Signature H. J. Owen (M. D. or other)
 Address FULTON Mo Date signed 4.24.44

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 5-8-44

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..... *E. E. White*.....

Licensed Embalmer No..... 4168.....

P. O. Address..... Fulton, 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.