

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15664
State File No. 15664

FILED MAY 15 1944

Registration District No. 5/844

Primary Registration District No. 30-60-171

Registrar's No. _____

1. PLACE OF DEATH:
(a) County. St. Francois
(b) City or town. Farmington RURAL St. Francois
(c) Name of hospital or institution:
Mo. State Hospital No. 4
(If not in hospital or institution, write street number or locality)
(d) Length of stay: In hospital or institution. 5 yrs. 7 mos. 22
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State. Missouri (b) County. Ripley
(c) City or town. Doniphan RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CHARLES THOMAS BEANE (BEAN)

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month April day 21 year 1944 hour 4 minute 20 P M.

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

21. I hereby certify that I attended the deceased from 3-20-44 to 4-21-44 that I last saw him alive on 4-21-44 and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife. None 6. (c) Age of husband or wife if alive. _____ years

Immediate cause of death. Pulmonary Tuberculosis?

7. Birth date of deceased. September 3, 1900
(Month) (Day) (Year)

Duration 13 1/2

8. AGE:	Years	Months	Days	If less than one day
	<u>43</u>	<u>7</u>	<u>18</u>	hr. _____ min. _____

Due to _____
Due to _____

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

Other conditions. Tubercular meningitis?
(Include pregnancy within 3 months of death)

10. Usual occupation. Common labor

Major findings: Cachexia

11. Industry or business _____

MOTHER FATHER } 12. Name. Milles Bean

PHYSICIAN _____

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

Of operations _____

14. Maiden name. Cora Bell Jones

Of autopsy No autopsy

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

Underline the cause to which death should be charged statistically.

16. (a) Informant. Records State Hospital No. 4 Farmington, Missouri

17. (a) Burial (b) Date thereof. 4-24-44
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director. Berl J. Miller
(b) Address. Farmington, Mo.

19. (a) 4-26-44 (b) J. J. Klobner
(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? _____

23. Signature Daniel Bashaw (M. D. or other) _____
Address State, Mo. Date signed 4-22-44

RECEIVED

5-13-44

District Health Officer No. 4

District File Number 544-383

Date Filed 5-13-44

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.....

~~Not~~ Embalmed

..... Registered Apprentice No.

working under my personal supervision.

Signed *Carl J. Miller*

Licensed Embalmer No. 3750

P. O. Address *Farmington, CT*

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.