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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 13 1944

Registration District No. 2 1 7

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 22093

Primary Registration District No. 4-3-3-95804 Registrar's No. 38

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

1. PLACE OF DEATH:
(a) County: Monroe
(b) City or town: Jackson Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Monroe Co. Infirmary
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Monroe
(c) City or town: Perna 69
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: BURLEY BEAUCHAMP
3. (b) If veteran, name war: ✓
3. (c) Social Security No. ✓

4. Sex: MALE
5. Color or race: NEGRO
6. (a) Single, widowed, married, divorced: MARRIED
6. (b) Name of husband or wife: N. K.
6. (c) Age of husband or wife if alive: N. K. years
7. Birth date of deceased: N. K. (Month) (Day) (Year)

8. AGE: Years 67 Months Days If less than one day hr. min.

9. Birthplace: Monroe Co. (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation: Farm Laborer
11. Industry or business:
FATHER 12. Name: N. K.
13. Birthplace: N. K. (City, town, or county) 0 (State or foreign country)
MOTHER 14. Maiden name: N. K.
15. Birthplace: N. K. (City, town, or county) 0 (State or foreign country)
16. (a) Informant: Infirmary Records
(b) Address:
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 6-18-44 (Month) (Day) (Year)
(c) Place: burial or cremation: WALNUT GROVE
18. (a) Signature of funeral director: NONE
(b) Address: ~~Paris, Missouri~~
19. (a) 6-18-44 (Date received local registrar) M. Sexton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18 year 1944 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from April 4, 1944 to June 18, 1944 that I last saw him alive on June 18, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebrovascular Insult of Hemiplegia — Duration
Due to: Nephritis — N. K.
Due to:
Other conditions (Include pregnancy within 3 months of death): 559
Major findings:
Of operations:
Of autopsy: no

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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: Geo. M. [illegible] (M. D. or other)
Address: Paris Mo Date signed: June 18, 44

1514 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 7-44-1313
Date Filed JUL 12 1944

STATEMENT BY LICENSED EMBALMER

Not Embalmed

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.