

No. 2  
M-5-43  
5-17-39  
X36671

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 24877  
Registrar's No. 332

FILED JUL 26 1944

Registration District No. 196

Primary Registration District No. 2001

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

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution St. Johns  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Days  
Specify whether

In this community 46 years  
years, months or days

3. (a) PRINT FULL NAME Maggie Beasley

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased July 19 1857  
(Month) (Day) (Year)

8. AGE: Years 84 Months 11 Days 15  
If less than one day \_\_\_\_\_ by \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name John Sweeney

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

14. Maiden name Mary Sullivan

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

16. (a) Informant Mrs. Maud Charlow Fanning

(b) Address \_\_\_\_\_

17. (a) Burial  
(Burial, cremation, or removal)

(b) Date thereof July 7, 1944  
(Month) (Day) (Year)

(c) Place: burial or cremation St. Johns Cem.

18. (a) Signature of funeral director Hombell - Weldon

(b) Address Joplin Mo.

19. (a) 7-6-44  
(Date received local registrar)

(b) John Sweeney  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper

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

(d) Street No. 414 Kentucky Ave  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 4  
year 1944 hour \_\_\_\_\_ minute 4:15 P.M.

21. I hereby certify that I attended the deceased from 7/3/44 to 7/4/44  
that I last saw her alive on 7/3/44 and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocarditis

Due to Shock

Due to Laceration of hip

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Much 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 work)

(c) Means of injury \_\_\_\_\_

23. Signature John Sweeney (M. D. or other) \_\_\_\_\_

Address Joplin Mo. Date signed 7/6/44

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

1274

44-6-576

**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.....

*Cecilia Thomhill*

Licensed Embalmer No.....

*3590*

P. O. Address.....

*Joplin, 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.**

Registration District No. 156 Primary Registration District No. 2001

**1. PLACE OF DEATH:**  
(a) County Jasper  
(b) City or town Joplin  
(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  
In this community \_\_\_\_\_ years, months or days)

**3. (a) PRINT FULL NAME** Maggie Bearley  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased July 19 (Month) (Day) (Year)

8. AGE: Years 84 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace Penn. (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) (Burial, cremation, or removal) \_\_\_\_\_ (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 \_\_\_\_\_ year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to Shock  
Due to Lacerated hip  
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) Accident  
(b) Date of occurrence 7/2/44  
(c) Where did injury occur? Home Joplin Mo. Jasper (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 Fell off porch  
23. Signature J. H. Schuyler (M. D. or other) \_\_\_\_\_ Date signed \_\_\_\_\_

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

**SUPPLEMENTAL**

MOTHER FATHER

5 1945

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