

V. S. No. 2
100M-5-43
Rev. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 15 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25267**
Registrar's No. **22**

Registration District No. **238**

Primary Registration District No. **4355**

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

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town New Madrid
(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 _____)

2. USUAL RESIDENCE OF DECEASED:
(a) State New Madrid (b) County 72
(c) City or town New Madrid 7
(If outside city or town limits, write "RURAL") 0
(d) Street No. Mill 67
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Harris Stanley Beck.
3. (b) If veteran, _____ **3. (c) Social Security** _____
name war _____ No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 11
year 44 hour 8:30 P minute _____ M. _____
21. I hereby certify that I attended the deceased from _____
7/11, 1944, to 7/11, 1944
that I last saw him _____ alive on 7/11, 1944
and that death occurred on the date and hour stated above.

4. Sex M. **5. Color or race** W.
6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if** _____
alive _____ years
7. Birth date of deceased April 22 43
(Month) (Day) (Year)

Immediate cause of death whooping cough
Due to _____
Due to _____

8. AGE:	Years	Months	Days	If less than one day
	<u>1</u>	<u>2</u>	<u>14</u>	<u>5:30 P.M.</u> hr. min.

Other conditions colitis **9**
(Include pregnancy within 3 months of death)

9. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country) 0
10. Usual occupation None

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

11. Industry or business None
12. Name George G. Beck
13. Birthplace Mo. (City, town, or county) (State or foreign country) 0
14. Maiden name Marion Hollister
15. Birthplace Mo. (City, town, or county) (State or foreign country) 0

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? _____

16. (a) Informant Marion Beck
(b) Address New Madrid Mo.
17. (a) _____ **(b) Date thereof** 7/12/44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Harris Cemetery

While at work? _____ (Specify type of place)
(2) Means of injury _____
23. Signature D. J. Allen M.D. (M.D. or other)
Address New Madrid **Date signed** 7/12/44

18. (a) Signature of funeral director L.H. Stoll
(b) Address Delaware Mo.
19. (a) 7-20-44 **(b)** Helen Land Jones
(Date received local registrar) (Registrar's signature)

RECEIVED

District Health Office No. 2,

District File Number 844-1135

Date Filed 8-11-44

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.....

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.