

S. No. 2  
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Rev. 5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

FILED OCT 24 1944

Registration District No. 199

Primary Registration District No. 1002

Registrar's No. 4019

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Lake Side Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 12 Hrs. (Specify whether  
In this community 12 Hrs. (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 20  
(c) City or town Sedalia 6  
(If outside city or town limits, write "RURAL") 4  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country. 1

3. (a) PRINT FULL NAME Kathleen M. Beaman

3. (b) If veteran, name war. no 3. (c) Social Security No. 498 22 8908

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Thomas E. Beaman 6. (c) Age of husband or wife if alive 58 years  
7. Birth date of deceased Aug 8 1901  
(Month) (Day) (Year)

8. AGE: Years 43 42 Months 1 Days 27 If less than one day hr. min.

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

10. Usual occupation Waitress

11. Industry or business No Record

12. Name No Record

13. Birthplace No record  
(City, town, or county) (State or foreign country)

14. Maiden name No record

15. Birthplace No Record  
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas Beaman

(b) Address Sedalia Missouri

17. (a) Removal (b) Date thereof Oct 6 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sedalia Missouri

18. (a) Signature of funeral director Mrs C.L. Forster

(b) Address 918 Brooklyn

19. (a) 10-7-44 (b) T.E. Brown (DZ)  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 5  
year 1944 hour 7 minute 45P M.

21. I hereby certify that I attended the deceased from Respectfully \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Acute coronary occlusion

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions massive collapse of rd. lung  
(include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy see above 94a

Duration

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?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature A.E. Walker MD (M. D. or other)

Address 23rd & McPherson Date signed 10/6/44

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

SEP 30 1948

OCT 23 1944

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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.....

*J. P. Herrick*

Licensed Embalmer No. *3599*

P. O. Address *St. Louis, 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.