

V. S. No. 2  
OM-9-4-41  
Rev. 5-17-39  
I X29484

FILED DEC 12 1944

Registration District No. **7**

Primary Registration District No. **3008**

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

1. PLACE OF DEATH:

(a) County Fulton Calloway

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

(c) Name of hospital or institution: State Hospital No 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution total 25 days  
(Specify whether)

In this community same  
years, months or days

3. (a) PRINT FULL NAME LUCY BECKMAN

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 single

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: 1860  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>84</u>			hr. _____ min.

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

10. Usual occupation Housewife

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

MOTHER FATHER

12. Name George Beckman

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

14. Maiden name Emmie M ?

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

16. (a) Informant Records State Hosp No 1

(b) Address Fulton Mo

17. (a) Removal (b) Date thereof 11/13/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Herman, Mo

18. (a) Signature of funeral director Hallase Funeral Home  
While at work? \_\_\_\_\_ (Specify type of place)

(b) Address Fulton, Mo D. E. Browning (c) Means of injury \_\_\_\_\_

19. (a) 11-13-1944 (b) Joan Morrison  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gasconade

(c) City or town Herman 14  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 12  
year 1944 hour 5 minute 30 M.

21. I hereby certify that I attended the deceased from Nov 1 - 1944  
to Nov 12 1944  
that I last saw her alive on Nov 12 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized arteriosclerosis

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

Due to 97

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

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

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

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

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? \_\_\_\_\_

(3) Signature D E Sherrill (M. D. or other) \_\_\_\_\_  
Address Fulton Mo Date signed 11/12/44

RECEIVED  
District Health Officer No. 9,

District File Number

Date Filed 12-11-44

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

*Denzil C. Browning*

Licensed Embalmer No. 2724

P. O. Address *H. C. 2nd*

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.