

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16649

State File No.

FILED JUN 14 1945

Registration District No. 74

Primary Registration District No. 4136

Registrar's No. 33-26

1. PLACE OF DEATH:

(a) County Clinton
(b) City or town Plattsburg
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 50 years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clinton
(c) City or town Plattsburg, Mo. 25
(If outside city or town limits, write "RURAL") 3
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME LEO HARRISON BEARD

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife Josephine 6. (c) Age of husband or wife if alive 79 years
7. Birth date of deceased February 14, 1863
(Month) (Day) (Year)

8. AGE: Years 82 Months 2 Days 21 If less than one day hr. _____ min. _____

9. Birthplace Yerxa County Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Retired farmer

11. Industry or business _____

12. Name W. R. Beard

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

14. Maiden name Sarah Frances Halbert

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

16. (a) Informant Mrs. Fritz Harrison

(b) Address Plattsburg, Mo.

17. (a) BURIAL (b) Date thereof 5 7 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cemetery

18. (a) Signature of funeral director Funeral Home

(b) Address Plattsburg, Mo.

19. (a) 5-7-45 (b) M. W. C. Harrison
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5
year 1945 hour 5 minute PM

21. I hereby certify that I attended the deceased from Mar 19, 1945 to May 5, 1945
that I last saw him alive on May 5, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: myocarditic Duration 7 da
Due to Intestinal hemorrhage 6 da
Due to Polyposis sigmoid 3 yrs
Other conditions: Adenoma Prostate 6 mo
(Include pregnancy within 3 months of death)

Major findings: Of operations none
Of autopsy none 5 W
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 0
23. Signature M. W. C. Harrison (M. D. or other) MD
Address Plattsburg Mo May 7-45

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

25
5
0

1085

RECEIVED
District Health Officer No. 11,
District File Number
Date Filed

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. G. Lyon
Licensed Embalmer No. 952
P. O. Address Stewartville

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.