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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18330

State File No.

FILED JUN 9 1945
Registration District No. 322

Primary Registration District No. 4472

Registrar's No. 3

1. PLACE OF DEATH:

(a) County. SALINE

(b) City or town. MIAMI MO
(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 _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline 97

(c) City or town Miami MO
(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 _____

3. (a) PRINT FULL NAME MILLIE BEASON

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 30 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

54 10 28 hr. min.

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

10. Usual occupation Route work

11. Industry or business _____

MOTHER FATHER

12. Name X Gangle Graves

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

14. Maiden name X Helen Folisher

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

16. (a) Informant X Helen Graves

(b) Address MIAMI MO

17. (a) MIAMI (b) Date thereof MAY 20 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Miami

18. (a) Signature of funeral director Campbell Beason

(b) Address Marshall mo

19. (a) May 25-45 (b) Mrs. John Giger
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18
year 1945 hour 11 minute 30 M.

21. I hereby certify that I attended the deceased from held inquest May 18 1945
that I last saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to _____

Due to Epilepsy

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations gmo

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) _____

(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? _____

(Specify type of place) _____

While at work? _____ (e) Means of injury 3

23. Signature P. L. Lawless Coroner (M. D. or other) _____
Address Mars. Mo. Date signed 5-18-45

1211

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 6/7/45

JUN 20 1945

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, by
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed Jan W. Lewis

Licensed Embalmer No. 1171

P. O. Address Marshall MD

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. 322

Primary Registration District No. 4472

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Saline
 (b) City or town Miami
 (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 Milhe Beason
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race B 6. (a) ~~Single, widowed, married,~~
~~divorced.~~ (A)
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
 alive _____ years
 7. Birth date of deceased July 20 1885
 (Month) (Day) (Year)

8. AGE: Years 54 Months _____ Days _____ If less than one day
 hr. _____ min.

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

10. Usual occupation _____
 11. Industry or business _____
 MOTHER FATHER { 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) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
 (b) Address _____
 19. (a) _____ (b) Mrs. John G. Giger
 (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 _____ Day _____
 year 1945 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ to _____, 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 _____
 Due to _____
 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) _____
 (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)
 (c) Means of injury _____
 23. Signature _____ (M. D. or other)
 Address _____ Date signed _____

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

SUPPLEMENTARY

18330