

FILED OCT 30 1945

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 77

Primary Registration District No. 3016

Registrar's No. 229

1. PLACE OF DEATH:

(a) County Cole  
(b) City or town Jefferson City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Mary's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 20 yrs.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole 26  
(c) City or town Jefferson City 5  
(If outside city or town limits, write "RURAL")  
(d) Street No. 11519-W High 4  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Math H. Bescheinen

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

4. Sex Male 5. Color White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Anna 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July 21 1871  
(Month) (Day) (Year)

8. AGE: Years 74 Months 2 Days 28 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Loose Creek Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Retail Farmer

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

MOTHER FATHER { 12. Name Henry Bescheinen  
13. Birthplace Loose Creek Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Gertrude Unknown  
15. Birthplace Loose Creek Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Anna Bescheinen

(b) Address 519-W High

17. (a) Burial (b) Date thereof Oct 22 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter's

18. (a) Signature of funeral director James Lewis

(b) Address 700 Jefferson

19. (a) 10-22-45 (b) R.P. Dorris MD  
(Date received local registrar) (Registrar's signature) NR

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 18  
year 1945 hour 7 minute 50 a.m.

21. I hereby certify that I attended the deceased from Oct 15, 1945, to Oct 18, 1945;  
that I last saw him alive on Oct 18, 1945;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 3 days

Due to Hypertension

Due to Hypertensive heart disease

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

Major findings: Of operations \_\_\_\_\_ Of autopsy 30  
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 J. Kanagawa (M. D. or other) MD

Address 129 E. High St Date signed 10/19/45

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

RECEIVED

District Health Officer No. 9,

District File Number \_\_\_\_\_

Date Filed 10.29-45

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. W. Anderson

Licensed Embalmer No. 3641

P. O. Address J. W. Anderson

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.