

**FILED** Dec 29 1945

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 69

**1. PLACE OF DEATH:**  
 (a) County Adair  
 (b) City or town Kirksville, Missouri  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Grim-Smith Hospital & Clinic  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 Hours  
 (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Schulyer **98**  
 (c) City or town Lancaster  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location) 1  
 (e) Citizen of foreign country?  (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Eddie Dale Beeler  
**3. (b) If veteran,** name war \_\_\_\_\_ **3. (c) Social Security** No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month NOV. day 26  
 year 1945 hour 4:30 A.M. minute \_\_\_\_\_ M.  
**21. I hereby certify that I attended the deceased from** November 26, 1945, to November 26, 1945  
 that I last saw him alive on November 26, 1945,  
 and that death occurred on the date and hour stated above.

**4. Sex** Male **5. Color or race** White  
**6. (a) Single, widowed, married,** divorced Newborn  
**6. (c) Age of husband or wife if** alive years \_\_\_\_\_  
**7. Birth date of deceased** Nov 26 1945  
 (Month) (Day) (Year)

Immediate cause of death Atelectasis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Premature 7 1/2 months  
 (Include pregnancy within 3 months of death)

**8. AGE:** Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 4 hr. \_\_\_\_\_ min.  
**9. Birthplace** Kirksville Mo  
 (City, town, or county) (State or foreign country)  
**10. Usual occupation** \_\_\_\_\_  
**11. Industry or business** \_\_\_\_\_

Major findings: 159  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

**MOTHER FATHER**  
**12. Name** Dale Larve Beeler  
**13. Birthplace** Lancaster, Missouri  
 (City, town, or county) (State or foreign country)  
**14. Maiden name** Elizabeth Moore  
**15. Birthplace** Glenwood, Missouri  
 (City, town, or county) (State or foreign country)  
**16. (a) Informant** Dale Larve Beeler  
**(b) Address** Lancaster, Missouri  
**17. (a)** Burial **(b) Date thereof** 11 26 45  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** Lancaster Cemetery  
**18. (a) Signature of funeral director** P.O. Stanton  
**(b) Address** Lancaster Mo  
**19. (a)** 11-29-45 **(b) Kate Lambert**  
 (Date received local registrar) (Registrar's signature)

**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 \_\_\_\_\_  
**23. Signature** R.E. Vaughan (M. D. or other) D.O.  
 Address Lancaster Mo Date signed 11/26/45

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

RECEIVED

Chief Health Officer No. 10

District File Number 12-45-1881

Date Filed DEC. 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, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 3705

P. O. Address Manchester, N.H.

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.