

FILED APR 2 1948

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 351

Primary Registration District No. 6189

Registrar's No. 74

1. PLACE OF DEATH:

(a) County Jarvis Co
 (b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Russell Mill mo
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 30 years
years, months or days)

3. (a) PRINT FULL NAME PHOEBE M. BEELER

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

4. Sex F 5. Color or race white

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

7. Birth date of deceased Feb 1 1850
(Month) (Day) (Year)8. AGE: Years 90 Months _____ Days 26 If less than one day
hr. _____ min.9. Birthplace Christian Co mo
(City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business _____

12. Name Wesley Rogable13. Birthplace Ind
(City, town, or county) (State or foreign country)14. Maiden name Phoebie - Burlington15. Birthplace Ind
(City, town, or county) (State or foreign country)16. (a) Informant John W Beeler(b) Address Russell Mill mo17. (a) Burial (b) Date thereof Feb 28
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Brown Cemetery18. (a) Signature of funeral director Roller Funeral Home(b) Address Hannibal mo19. (a) 3/27/46 (b) C. R. Altman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jarvis 106
 (c) City or town Rural 0
(If outside city or town limits, write "RURAL")
 (d) Street No. Russell Mill mo 0
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 27
year 1946 hour 5:10 minute AM21. I hereby certify that I attended the deceased from November
1945 to February 27, 1946;
that I last saw her alive on January 28, 1946
and that death occurred on the date and hour stated above.Immediate cause of death Coronary
occlusion Duration _____Due to Chronic Coronary
DISEASE.

Due to _____

Other conditions General Carcinomatosis
(Include pregnancy within 3 months of death)Major findings:
Of operations _____

Of autopsy _____

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) (e) Means of injury _____23. Signature DW Clayton (M. D. or other) _____Address Hannibal, MO Date signed 2-27-46

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

RECEIVED

District Health Officer No. 6

District File Number 346-412

Date Filed MAR 29 1946

This Body was Not Embalmed

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 *Lorraine L Hall*

Licensed Embalmer No. *2784*

P. O. Address *Hainesville, Mo*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH.

State File No. April
Registrar's No. 74

Registration District No. 351

Primary Registration District No. 6189

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

10872

1. PLACE OF DEATH:

(a) County Janey
(b) City or town Rural
(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

Phoebe M. Beelen

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race w

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Feb 1
(Month) (Day) (Year)

8. AGE: Years 90 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 _____

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) _____
(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 7
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

General Carcinomatosis

Due to Carcinoma of Sigmoid Colon

Due to _____

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

Major findings: Of operations _____

Of autopsy 462

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 H W Clapp (M. D. or other) _____

Address Forsyth, Mo. Date signed 4-6-46

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

11961