

FILED APR 18 1947

State File No.

Registration District No. 290

Primary Registration District No. 4427

Registrar's No. 40

1. PLACE OF DEATH

(a) County PULASKI
(b) City or town WAYNESVILLE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: DE WITT HOSPITAL
(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)

3. (a) PRINT FULL NAME

LEON BEASLEY

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex MALE 5. Color or race W

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years 28 1947 (Month) (Day) (Year)

7. Birth date of deceased FEB. 28 1947

8. AGE: Years 0 Months 0 Days 3 If less than one day hr. min.

9. Birthplace WAYNESVILLE MO

(City, town, or county) (State or foreign country)

10. Usual occupation CHILD

11. Industry or business

12. Name TOM BEASLEY

13. Birthplace TEXAS CO MO

14. Maiden name SARAH BULLOCK

15. Birthplace TEXAS CO MO

16. (a) Informant TOM BEASLEY

(b) Address RAYMONDVILLE, MO

17. (a) BURIAL (b) Date thereof 3-4-47

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MAHAN

18. (a) Signature of funeral director Agnes V. Elliott

(b) Address HOUSTON MO

19. (a) 4-2-47 (b) James B. McClintock

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County TEXAS
(c) City or town RAYMONDVILLE
(If outside city or town limits, write "RURAL")
(d) Street No. 4 miles N.E.
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 3
year 1947 hour 11 minute 30 P.

21. I hereby certify that I attended the deceased from 2-28- 1947 to 3-2- 1947
that I last saw him alive on 3-2- 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Intra-cranial hemorrhage, 2 days

Due to Compression during Labor.

Due to

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

Major findings: Of operations 160

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?

While at work? (Specify type of place)

(e) Means of injury 2

23. Signature Henry R. Ross (M. D. or other) D.O.

Address Raymondville, MO Date signed 3-2-47

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.....

No Embalming....., Registered Apprentice No.....,
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.