. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26768

FILED AUG 16 1947

Registration District No. ..... Primary Registration District No. 1000 Registrar's No. 947

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 509 No. Noyes Blvd.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 10 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 304 So. 17th
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Edward M. Beck
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Myrtle Beck
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased August (Month) 7, (Day) 1877 (Year)

8. AGE:	Years	Months	Days	If less than one day
√	69	11	26	..... hr. ..... min.

9. Birthplace Sheridan (City, town, or county) Iowa (State or foreign country)
10. Usual occupation Groceryman
11. Industry or business Grocery
FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)
16. (a) Informant Mrs. Myrtle Beck
(b) Address St. Joseph, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/5/47 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park
18. (a) Signature of funeral director Heaton-Bowman
(b) Address St. Joseph, Mo.
19. (a) 8-11-47 (Date received local registrar) (b) E. L. Jenkins (Registrar's signature) 347

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 3
year 1947 hour 6 minute 10 P. M.
21. I hereby certify that I attended the deceased from July 17, 1947 ....., 19..., to Aug 3, 1947
that I last saw him alive on 12 N Aug 3, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Failure; Pulmonary Congestion, Hypertensive
Due to Heart Disease
Due to Heart failure subsequent to accident sustained July 17.
Other conditions Fract Ribs 5, 6, 7, 8, 9 to St. of Spine July 17.
(Include pregnancy within 3 months of death)
~~Major findings~~ ~~Of operation~~ in fall from wall of terrace at his home.
~~Of autop.~~ Chest immobilized c̄ tape

Duration 72 hrs.
Yrs. ?
186

PHYSICIAN
Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence 7-17-47
(c) Where did injury occur? St. Joseph (City or town) Buchanan (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home, fell from wall of terrace (Specify type of place)
While at work? no (e) Means of injury fall
23. Signature Robert L. Conrad (M. D. or other) MD
Address St. Joseph, Mo Date signed 8/5/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 Francis Wayland, Registered Apprentice No. 444, working under my personal supervision.

Signed Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 6 10th St. Joseph, 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.