No. 2
-1/47
-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 29 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31091

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3963

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 929 Paseo (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community: 25 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 48
(c) City or town: Kansas City (If outside city or town limits, write "RURAL") 3
(d) Street No.: 929 Paseo (If rural, give location) 8
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME: Benjamin Fell Beazell
3. (b) If veteran, name war: No.
3. (c) Social Security No.: 495-20-8194
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Bertha A. Beazell
6. (c) Age of husband or wife if alive: 73 years
7. Birth date of deceased: Sept 13 1864 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
83	0	3	..... hr. ..... min.

9. Birthplace: Pa. (City, town, or county) (State or foreign country)
10. Usual occupation: Carpenter
11. Industry or business:

FATHER
12. Name: Samuel W. Beazell
13. Birthplace: Pa. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Mary Jane Van Kirk
15. Birthplace: Pa. (City, town, or county) (State or foreign country)

16. (a) Informant: Bertha Beazell
(b) Address: 929 Paseo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: Sept. 19 1947 (Month) (Day) (Year)
(c) Place: burial or cremation: Chillicothe Missouri
18. (a) Signature of funeral director: Mrs C. L. Forster
(b) Address: (918 Brooklyn Kas. City Mo.
19. (a) 9-18-47 (Date received local registrar) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Sept day: 16 year: 1947 hour: 5 minute: A.M.
21. I hereby certify that I attended the deceased from: Brown 19..., to ..... 19...; that I last saw h... alive on ..... 19...; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death: Coronary Insufficiency
Due to: Cutis reflexion
Due to:
Other conditions (Include pregnancy within 3 months of death): 95C
Major findings: Of operations:
Of autopsy: no
History & Injection

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)
(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: 2
23. Signature: Lewis C. Walker (M. D. or other) Coron
Address: 1424 Nfm MKY Date signed: 9-17-47

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 me

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

working under my personal supervision.

Signed Theron A. Redmon

Licensed Embalmer No. 2737

P. O. Address K.C. 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.