

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33470

State File No. _____

Registration District No. 381

Primary Registration District No. 6179

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Rural - Jackson Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 1 year years, months or days

3. (a) PRINT FULL NAME EMMA KAPPER BEEZLEY
3. (b) If veteran, name war _____ 3. (c) Social Security No. 1

4. Sex F 5. Color or race W
6. (b) Name of husband or wife LAWRENCE BEEZLEY
7. Birth date of deceased DEC 21 1889
(Month) (Day) (Year)

8. AGE: Years 57 Months 8 Days 22
If less than one day hr. _____ min. _____

9. Birthplace MT PLEASANT Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Otto Kappers

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Emily Elizabeth Elston

15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Dore Pag

(b) Address R4., Milan, Mo.

17. (a) Burial (b) Date thereof 9-15-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green City, Mo.

18. (a) Signature of funeral director Wm. E. Hunt
(b) Address Green City, Mo.

19. (a) Sept 18-1947 (b) Mrs. H. B. Harris
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County 999
(c) City or town MT Pleasant 13
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 2
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 12
year 1947 hour 4 minute 30 M.

21. I hereby certify that I attended the deceased from Sept 12
1947, to Sept 12, 1947
that I last saw him alive on Sept 12, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Asthma with Duration _____
Constriction of Lungs and
MI pleuritis

Due to _____

Due to _____

Other conditions _____
(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)

While at work? _____ (e) Means of injury 6

23. Signature W. Herington MD (M. D. or other) _____

Address Green City, Mo. Date signed 9-15-47

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

MOTHER FATHER

Underline the cause to be stated. If death was due to external causes, state the place and date of occurrence. If death was due to internal causes, state the organ or system affected. If death was due to external causes, state the place and date of occurrence. If death was due to internal causes, state the organ or system affected. If death was due to external causes, state the place and date of occurrence. If death was due to internal causes, state the organ or system affected.

REQUESTED

FFB 16 1948

RECEIVED
District Health Officer No. 9472
District File Number 9472
Date Filed SEP 23 1947

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 Archibald Wade
Licensed Embalmer No. 3037
P. O. Address Green City

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. *Oct*

Registration District No. *39*

Primary Registration District No. *6179*

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County *Sullivan*
(b) City or town *Paris*
(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

Emma K. Beasley

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 _____

See 2/1

8. AGE:

Years *57*

Months _____

Days _____

If less than one day _____

hr. _____ min. _____

9. Birthplace _____

(City, town, or county)

(State or foreign country) *Illinois*

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) _____

(Burial, cremation, or removal)

- (b) Date thereof _____

(Month) (Day) (Year)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) _____

(Date received local registrar)

- (b) _____

(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 _____ Year *1948* Hour _____ minute _____ M.

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

- Due to _____
Due to _____

- Other conditions _____ (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? _____

- While at work? _____ (Specify type of place) Means of injury _____

23. Signature *W. H. ... M.D.* (M. D. or other) _____
Address *Paris City Mo* Date signed *9-29-48*

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

131B

33470