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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33956**

FILED OCT 24 1947

Registration District No. _____ Primary Registration District No. 3012 Registrar's No. 153

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

1. PLACE OF DEATH:
 (a) County CLAY
 (b) City or town EXCELSIOR SPRINGS
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
BALL CLINIC
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 18 DAYS
(Specify whether
 In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State ILLINOIS (b) County _____ 999
 (c) City or town SPRINGFIELD 11
(If outside city or town limits, write "RURAL")
 (d) Street No. 125 WEST ADAMS 0
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No) 2
 If yes, name country _____

3. (a) PRINT FULL NAME VIENNA LISA BECKER
 3. (b) If veteran, name war NO 3. (c) Social Security No. NONE
 4. Sex FEMALE 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced WIDOWED
 6. (b) Name of husband or wife Peter Becker 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased September 24 1869
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month October day 3rd
 year 1947 hour 8⁰⁰ minute _____ P. M. _____
 21. I hereby certify that I attended the deceased from September 18th
1947, to Oct 3rd 1947
 that I last saw her alive on Oct 3rd 1947
 and that death occurred on the date and hour stated above. 1947

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>0</u>	<u>9</u>	hr. _____ min. _____

Immediate cause of death Diabetic Crisis - Coma. Duration _____
 Due to _____
 Due to _____
 Other conditions 61
(Include pregnancy within 3 months of death)

9. Birthplace ST. CLAIR COUNTY ILLINOIS
(City, town, or county) (State or foreign country)
 10. Usual occupation CHIROPRACTOR

PHYSICIAN
 Major findings: no operation
 Of operations _____
 Of autopsy no autopsy
 Underline the cause to which death should be charged statistically.

11. Industry or business
 12. Name Ish Thomas 7
 13. Birthplace Unknown 7
(City, town, or county) (State or foreign country)
 14. Maiden name Vienna Holcum
 15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records 7
 (b) Address Excelsior Springs, Missouri
 17. (a) REMOVAL (b) Date thereof OCT. 4, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation SPRINGFIELD, ILLINOIS
 18. (a) Signature of funeral director Clark Prichard
 (b) Address EXCELSIOR SPRINGS, MO.
 19. (a) 10/4/47 (b) Caroline Nulching
(Date received local registrar) (Registrar's signature)

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 0
 23. Signature W. Purvance M.D. (M. D. or other) _____
 Address Excelsior Springs, Mo. Date signed 10-4-47

RECEIVED
District Health Officer No. 8,

District File Number _____

Date Filed 10-23-67

OCT 25 1967

OCT 25 1967

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 _____

Albert E. White

Licensed Embalmer No. 41689

P. O. Address Excelsior Spring, 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.