

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37878**

FILED DEC 15 1947
Registration District No. **133**

Primary Registration District No. **5486**

Registrar's No. **9/3**

1. PLACE OF DEATH:

(a) County **Harrison**
(b) City or town **Martinsville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **none**
(If not in hospital or institution, write street number or location) **1**
(d) Length of stay: In hospital or institution **no** (Specify whether)
In this community **87 yrs.**
years, months or days

3. (a) PRINT FULL NAME **Adella Octavio Beeks.**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **no**

4. Sex **Female.** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **widowed.**

6. (b) Name of husband or wife **Samuel W.** 6. (c) Age of husband or wife if alive **Dec.** years

7. Birth date of deceased **11-12-1860**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 0 10 hr. min.

9. Birthplace **Harrison County, Missouri?**
(City, town, or county) (State or foreign country)

10. Usual occupation **none**

11. Industry or business **none**

12. Name **Abel Willis Allen**

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

14. Maiden name **Arabelle Dunkerson**

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

16. (a) Informant **James Beeks.**

(b) Address **Bethany, Mo.**

17. (a) **Burial** (b) Date thereof **11-26-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Allen Cemetery**

18. (a) Signature of funeral director **W. B. Klaas**

(b) Address **Bethany, Mo.**

19. (a) **Nov. 25-47** (b) **Zola Burris**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Harrison** **41**
(c) City or town **Martinsville, Mo.** **0**
(If outside city or town limits, write "RURAL")
(d) Street No. **4 Miles East. Sellers Trg.**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country **no** **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **22**
year **1947** hour **11** minute **10 P.M.**

21. I hereby certify that I attended the deceased from **Nov 22**
1947 to **Nov 22, 1947**
that I last saw her alive on **Nov 22 11 PM, 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Choke**
Myocarditis
Arteriosclerosis
Due to **Terminal Pneumonia**

Other conditions: **1**
(Include pregnancy within 3 months of death)

Major findings: **9/3/47**
Of operations **no**
Of autopsy **no**

PHYSICIAN

Underline the cause to 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?

While at work? (Specify type of place) (c) Means of injury **2**

23. Signature **A. B. Sheldahl** (M. D. or other) **DB**
Address **Bethany, Mo.** Date signed **11-25-47**

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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.....

M. B. Haas
M. B. Haas.

Licensed Embalmer No. 3899

P. O. Address. Bethany, 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.