

No. 300  
-10-47  
5-17-39  
I 3906

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
FILED MAR 13 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

8167

State File No. \_\_\_\_\_

Registrar's No. 28

Registration District No. \_\_\_\_\_

Primary Registration District No. 3012

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: Veterans Administration Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yrs. 11 mos. 9 days  
(Specify whether years, months or days)

In this community 2 yrs. 11 mos. 9 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Allen W. Beason

3. (b) If veteran, name war World War I

3. (c) Social Security No. Yes, remembered.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Frances E. Beason

6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased May 23 1901  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

46 9 9 hr. min.

9. Birthplace Fayetteville Arkansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Steel worker

11. Industry or business Sheffield Steel Co.

12. Name Allen W. Beason

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

14. Maiden name Anna May Powell

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

16. (a) Informant Hospital Records, Veterans Administration Hospital

(b) Address Excelsior Springs, Missouri

17. (a) Removal (b) Date thereof 3-3-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: removal; Kansas City, Missouri

18. (a) Signature of funeral director Glenn O. Hope  
HOPE FUNERAL HOME

(b) Address Excelsior Springs, Mo.

19. (a) 3/3/48 (b) Baroline Rutledge  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 2839 Askew  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2  
year 1948 hour 11:50 minute P M.

21. I hereby certify that I attended the deceased from March 23, 1945, to March 2, 1948, that I last saw him alive on March 2, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, pulmonary, reinfection type, active, far advanced, moderate symptoms. Broncho pleural fistula. Empyema, right.

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy Same as above.

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 \_\_\_\_\_

23. Signature Jack M. Leopard (M. D. or other) M. D.  
JACK M. LEOPARD Date signed 3-3-48  
Address Veterans Administration Hospital

MOTHER FATHER

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

13B

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 3-17-48

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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 Gas A. Moles

Licensed Embalmer No. 3296

P. O. Address Exp Springs 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.