

FILED AUG 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26434**

BIRTH NO. _____ REG. DIST. NO. **72** PRIMARY REG. DIST. NO. **6292** Registrar's No. **93**

1. PLACE OF DEATH a. COUNTY Clay Platte Township		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Clay	
b. CITY OR TOWN Smithville		c. CITY OR TOWN Smithville	
c. LENGTH OF STAY (in this place) 40 yrs.		d. STREET ADDRESS (If rural, give location) Platte Township	
d. FULL NAME OF HOSPITAL OR INSTITUTION at Home			
3. NAME OF DECEASED (Type or Print) a. (First) Golden		b. (Middle) A.	
c. (Last) BECK		4. DATE OF DEATH (Month) (Day) (Year) August 20, 1949	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH Oct. 6, 1882
9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months 10 Days 14	IF UNDER 12 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) Columbus, Nebraska	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME FRANK L. HARRISON	13b. MOTHER'S MAIDEN NAME ELIZABETH H. NEFF	14. NAME OF HUSBAND OR WIFE OTTO L. BECK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME OTTO L. BECK ADDRESS SMITHVILLE, MISSOURI	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) hypertension DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Coronary disease	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Aug 19, 1935 to Aug 20, 1949 , that I last saw the deceased alive on Aug 20, 1949 , and that death occurred at 4 1/2 m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Dr. Salzman M.D.		23b. ADDRESS Smithville Mo	23c. DATE SIGNED 8-21-49
24a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL	24b. DATE 8/22/49	24c. NAME OF CEMETERY OR CREMATORY I.O.O.F. CEMETERY	24d. LOCATION (City, town, or county) (State) Smithville, Missouri
DATE REC'D BY LOCAL REG. Aug 22, 1949	REGISTRAR'S SIGNATURE Beulah Kitchener	63	25. FUNERAL DIRECTOR'S SIGNATURE Macomas Funeral Home ADDRESS Smithville, Mo.

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

RECEIVED AUG 27

District Health Officer No. 8,

District File Number _____

Date Filed 8-27-49

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 AS

AS Student Embalmer No. AS
working under my personal supervision.

AS
Student
Student Embalmer

Signed Dwight B. Boyd
Licensed Embalmer No. 3940

P. O. Address Smithville, 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.