

FILED SEP 25 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29968

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 820

396
0

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

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Christian</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rogersville, Rural, Linden Twp</u>	
c. LENGTH OF STAY (In this place) <u>3 days</u>		d. STREET ADDRESS (If rural, give location) <u>1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Clark Oesophagus Hosp.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>NANCY</u> b. (Middle) <u>Kathryn</u> c. (Last) <u>Beasley</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 16 1950</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	
8. DATE OF BIRTH <u>Nov 17 1919</u>		9. AGE (In years last birthday) <u>30</u>		UNDER 1 YEAR IF UNDER 18 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Lugoff, S. Carolina</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					

13a. FATHER'S NAME <u>H.A. Hawkins</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Everett</u>	
--	--	--	--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>24830-2899</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Everett Beasley, Rogersville Mo.</u>	
--	--	---	--	---	--

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) <u>Acute Circulatory Failure</u>				INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>					
		DUE TO (b) <u>Myocardial Insufficiency due to Degenerative changes</u>					
		DUE TO (c) <u>Decompensated Rheumatic Heart Disease.</u>					
		II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				<u>416x</u>	

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 9-11-50, 1950, to 9-16-50, 1950, that I last saw the deceased alive on 9-16-50, 1950, and that death occurred at 1:35 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Lester J. Mason D.O.</u>		23b. ADDRESS <u>700 E. Sunshine - Springfield</u>		23c. DATE SIGNED <u>9-16-</u>	
--	--	---	--	-------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept. 19, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Roller Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Rogersville, Rural, Missouri</u>	
---	--	---------------------------------	--	---	--	---	--

DATE REC'D BY LOCAL REG. <u>9-19-50</u>		REGISTRAR'S SIGNATURE <u>W.E. Hawley M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Kelley-Fessell-Bergman, Rogersville Mo.</u>	
---	--	---	--	---	--

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed H. H. Kelley

Signed _____
Student Embalmer

Licensed Embalmer No. 3334

P. O. Address Fordland me.

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.