

FILED OCT 28 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33800

State File No. ....

Registrar's No. 385

BIRTH NO. .... REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Independence		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Independence	
d. FULL NAME OF HOSPITAL OR INSTITUTION 308 South Fuller		d. STREET ADDRESS (If rural, give location) 308 South Fuller	

3. NAME OF DECEASED (Type or Print) a. (First) EDITH	b. (Middle) BEARD	c. (Last) BEARD	4. DATE OF DEATH (Month) (Day) (Year) Sept. 28, 1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 11, 1876	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 17
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Centerville, Iowa	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Peter McCoy	13b. MOTHER'S MAIDEN NAME Nancy Fitzpatrick	14. NAME OF HUSBAND OR WIFE William Lee Beard
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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 Mrs. Eldron L. Robison, Indep., Mo.	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis		2 hours
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary sclerosis		Posterior

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Patient had an operation for benign prostatic hypertrophy - This operation was performed Sept 13, 1950 and she had recovered and gone home. And was apparently well & was discharged from hospital.	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from Sept 17, 1950, to Sept 28, 1950 that I last saw the deceased alive on Sept 28, 1950 and that death occurred at 11:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE C.H. Allen M.D.	(Degree or title)	23b. ADDRESS Independence, Mo	23c. DATE SIGNED Sept 29/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/2/50	24c. NAME OF CEMETERY OR CREMATORY Mound Grove Cemetery	24d. LOCATION (City, town, or county) (State) Jackson County, Missouri
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DATE REC'D BY LOCAL REG. Oct. 1, 1950	REGISTRAR'S SIGNATURE A.M. Speaks	25. FUNERAL DIRECTOR'S SIGNATURE Roland R. Speaks, Independence, Mo.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Stanley M. Seaton

Licensed Embalmer No. 4504

P. O. Address Independence, Missouri

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.