

FILED MAR 7 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4083

BIRTH NO. _____		REG. DIST. NO. 52		PRIMARY REG. DIST. NO. 3009		Registrar's No. 14	
1. PLACE OF DEATH a. COUNTY Cape Girardeau				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kentucky b. COUNTY Ohio			
b. CITY OR TOWN Jackson		c. LENGTH OF STAY (In this place) Sev. Mo.		c. CITY OR TOWN Hartford		8168	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deal Nursing Home				d. STREET ADDRESS Hartford, Ky			
1. NAME OF DECEASED (First or Initial) Mary		b. (Middle) Cox		c. (Last) Bean		4. DATE OF DEATH Feb. 23, 1951	
2. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed ✓		8. DATE OF BIRTH March 13, 1874	
9. AGE (In years, last birthday) 76		10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) At Home		11. BIRTHPLACE (City or foreign country) Hartford, Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Samule K. Cox		13b. MOTHER'S MAIDEN NAME Irene Brotherton		14. NAME OF HUSBAND OR WIFE Marvin Bean (dec'd)			
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 Fannie Goodin, Charleston, 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) <u>Arteriosclerosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Don't know</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) _____		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR _____			
22. I hereby certify that I attended the deceased from <u>Sept. 19, 1950</u> to <u>Feb. 21, 1951</u> , that I last saw the deceased <u>alive on Feb. 21, 1951</u> , and that death occurred at <u>5:15A m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>[Signature]</u> (Degree or title) M. D.				23b. ADDRESS Jackson, Mo		23c. DATE SIGNED 2/24/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/25/1951		24c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		24d. LOCATION (City, town, or county) (State) Charleston, Mo	
DATE REC'D BY LOCAL REG. Mar 3-51		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS THE NUNNELLE FUNERAL CHAPEL, Charleston Mo			

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

RECEIVED

MAR 6 1951

DISTRICT HEALTH OFFICE No. (

File No.

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 *John F. Munnice Jr*

Licensed Embalmer No. *3851*

P. O. Address *Charleston, W*

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.

William R. ...