

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

35647

State File No. ....

FILED OCT 19 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 4200 Registrar's No. 963

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Greene</u>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Ash Grove</u> ) | c. LENGTH OF STAY (in this place) _____ | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Ash Grove</u> <span style="float:right">0390</span>        |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Residence</u>                              |   | d. STREET ADDRESS (If rural, give location) _____  |  |

|                                     |                        |                            |                       |  |
|-------------------------------------|------------------------|----------------------------|-----------------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>ANNA</u> | b. (Middle) <u>LOUETTA</u> | c. (Last) <u>BEAL</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>October 13 53</u> |
|-------------------------------------|------------------------|----------------------------|-----------------------|--|

|                      |                               |   |                                       |   |   |   |
|----------------------|-------------------------------|---|---------------------------------------|---|---|---|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>March 1, 1868</u> | 9. AGE (in years last birthday) <u>85</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. 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 <u>Home</u> | 11. BIRTHPLACE (State or foreign country) <u>Polk County, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
|--|---|---|---|

|  |  |  |
|--|--|--|
| 13a. FATHER'S NAME <u>William Anderson</u> | 13b. MOTHER'S MAIDEN NAME (unknown) <u>Mc Daniel</u> | 14. NAME OF HUSBAND OR WIFE <u>Thomas Beal</u> |
|--|--|--|

|   |  |   |                               |
|---|--|---|-------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>W. A. Beal</u> | ADDRESS <u>Ash Grove, Mo.</u> |
|---|--|---|-------------------------------|

|   |   |  |                                  |
|---|---|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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   |  | INTERVAL BETWEEN ONSET AND DEATH |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Serility</u>  |  |                                  |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |                                  |
| II. OTHER SIGNIFICANT CONDITIONS<br>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) <u>794X</u> |
|--|--|---|

|  |  |                                  |
|--|--|----------------------------------|
| 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 June 28, 1953, to October 13, 1953, that I last saw the deceased alive on October 13, 1953 and that death occurred at 9:00p m., from the causes and on the date stated above.

|  |                                    |                                      |
|--|------------------------------------|--------------------------------------|
| 23a. SIGNATURE (Degree or title) <u>Thomas F. Matz, M.D.</u> | 23b. ADDRESS <u>Ash Grove, Mo.</u> | 23c. DATE SIGNED <u>Oct 14, 1953</u> |
|--|------------------------------------|--------------------------------------|

|   |                              |   |  |
|---|------------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Oct 15-1953</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Ridge Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>Polk Co., Mo.</u> |
|---|------------------------------|---|--|

|  |   |   |               |
|--|---|---|---------------|
| DATE REC'D BY LOCAL REG. <u>10-15-53</u> | REGISTRAR'S SIGNATURE <u>Edith Williamson</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Doyle Daniel Ash Grove Mo</u> | ADDRESS _____ |
|--|---|---|---------------|

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

**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 \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

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

Licensed Embalmer No. 4700

P. O. Address Ab. Dr.

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.