

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

State File No. **42097**

FILED DEC 21 1953

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **1285**

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY Buchanan		a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
c. LENGTH OF STAY (in this place) 12 years		d. STREET ADDRESS (If rural, give location) 2528 Pacific St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Methodist Hospital			

3. NAME OF DECEASED			4. DATE OF DEATH		
a. (First) Otis	b. (Middle) Leland	c. (Last) Beagle	(Month) December	(Day) 11	(Year) 1953

5. SEX male <input checked="" type="radio"/>	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <input checked="" type="checkbox"/> married	8. DATE OF BIRTH January 26, 1890	9. AGE (In years) 63	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) conductor	10b. KIND OF BUSINESS OR INDUSTRY railroad	11. BIRTHPLACE (State or foreign country) Andrew county, Missouri	12. CITIZENSHIP OF WHAT COUNTRY? USA
--	---	--	---

13a. FATHER'S NAME Dan Beagle	13b. MOTHER'S MAIDEN NAME Chrisie Reed	14. NAME OF HUSBAND OR WIFE Ruby Alice
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or date of service) 707-07-7188	17. INFORMANT'S SIGNATURE OR NAME Mrs. Otis Beagle, 2528 Pacific, St. Joseph, Mo	ADDRESS
--	--	---	----------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary infarction left lower lobe of lung		(b) <u>Coronary infarction & congestive failure</u>		5 days	
ANTECEDENT CAUSES <i>* This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		DUE TO (b) <u>Some evidence of congestive failure</u>		76 days	
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		due to coronary arterio-sclerosis		2 years	
		infectious hepatitis (viral)		2 years	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION cleared three weeks prior to death.	20. AUTOPSY? YES <input checked="" 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) 4201
---	---	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	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 Sept. 29, 1953, to Dec. 11, 1953, that I last saw the deceased alive on Dec. 11, 1953, and that death occurred at 9:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) T. L. Hoelder M.D.	23b. ADDRESS 419 Kirkpatrick Bldg., City	23c. DATE SIGNED 12-14-53
---	---	--

24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 12/14/1953	24c. NAME OF CEMETERY OR CREMATORY Burlington, Iowa	24d. LOCATION (City; town, or county) (State)
---	---------------------------------------	--	--

DATE REC'D BY LOCAL REG. Dec 15, 1953	REGISTRAR'S SIGNATURE Kathleen M. Allison	495	25. FUNERAL DIRECTOR'S SIGNATURE Heaton-Bauman Funeral Home - St Joseph	ADDRESS
--	--	------------	--	----------------

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48

1919

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 Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 So 10th St. Joseph, 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.