

STANDARD CERTIFICATE OF DEATH

State File No. **1167**

BIRTH NO. **FILED FEB 15 1954** REG. DIST. NO. **144** PRIMARY REG. DIST. NO. **5562** Registrar's No. **5**

0470

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

1. PLACE OF DEATH a. COUNTY Home		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Iron	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural - Arcadia		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural - Arcadia 6470	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home for Aged Baptists		1 1/2 Miles E. of Arcadia	
3. NAME OF DECEASED a. (First) Isabel b. (Middle) Beeding c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Jan 21 1954
5. SEX F.	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 13 - 1867
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Church work	11. BIRTHPLACE (City and State or Foreign Country) St Louis Mo
12. CITIZEN OF WHAT COUNTRY? US		13a. FATHER'S NAME Dr. Hugh Nelson	
13b. MOTHER'S MAIDEN NAME Janet Babin Archer		14. NAME OF HUSBAND OR WIFE E. Lockwood Beeding	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. UNIFORMANT'S SIGNATURE OR NAME Mrs Martha DeWoss - see		ADDRESS Baptist Home	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) meningitis subcal PRECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. (DUE TO (b) derms of Influenza non infective (DUE TO (c)	
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) 3400	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 Jan 14, 1954 , to Jan 21, 1954 , that I last saw the deceased alive on Jan 20, 1954 , and that death occurred at 12 P. m. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) C. M. Hulpatrick MD		23b. ADDRESS Lester ville Mo	
23c. DATE SIGNED 1/27/54		24a. BURIAL, CREMATION, REMOVAL (Specify) removal	
24b. DATE 1-22-54		24c. NAME OF CEMETERY OR CREMATORY St. Louis, Missouri	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bull-Campbell Mortuary 5165 Delmar Blvd. St. Louis Mo.	
DATE REC'D BY LOCAL REG. 2-13-54		REGISTRAR'S SIGNATURE Mrs. Aris Jones 125-1	

PER 15 1966

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.....

Licensed Embalmer No.....

P. O. Address.....

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.