

FILED JUN 22 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18729

BIRTH NO. _____ REG. DIST. NO. 140 PRIMARY REG. DIST. NO. 3024 Registrar's No. 47

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Howard	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fayette		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Richmond Twp.	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Lee Hospital		d. STREET ADDRESS (If rural, give location) R. F. D. #3	

3. NAME OF DECEASED (Type or Print)	a. (First) William	b. (Middle) Alfred	c. (Last) Besgrove	4. DATE OF DEATH (Month) (Day) (Year) June 11, 1954
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 8, 1871	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR 3 Months	IF UNDER 24 HRS. 0 Hours 0 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) Bridgewater, England	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME William Brownsy Besgrove	13b. MOTHER'S MAIDEN NAME Elizabeth Stowers	14. NAME OF HUSBAND OR WIFE Stella Jones
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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 ADDRESS Mrs. W. A. Besgrove Fayette, Mo
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 14 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Pneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Coronary Disease DUE TO (c) Endarteritis Obliterans		
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 4201	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) m.	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 **1-1** 19**54**, to **6-11** 19**54**, that I last saw the deceased alive on **6-11** 19**54**, and that death occurred at **6:27** m., from the causes and on the date stated above.

23a. SIGNATURE W. Bloom M.D. (Degree of title)	23b. ADDRESS Fayette Mo	23c. DATE SIGNED 6-17-54
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24a. BURIAL, CREMATION REMOVAL (Specify) Burial	24b. DATE 6/13/54	24c. NAME OF CEMETERY OR CREMATORY Fayette City Cemetery	24d. LOCATION (City, town, or county) (State) Fayette Missouri
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DATE REC'D BY LOCAL REG. 6-17-54	REGISTRAR'S SIGNATURE Mary K. Shell	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ralph A. Carr Fayette, Mo
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Ralph A. Carr

Signed _____

Student Embalmer

Licensed Embalmer No. *3340*

P. O. Address *Jayette Miss*

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.