

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 32787

FILED OCT 24 1955

BIRTH NO. 63895-55 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 912

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>WEBSTER</u>		
b. CITY (If outside corporate limits, write RURAL and give township) <u>SPRINGFIELD</u>		c. LENGTH OF STAY (In this place) <u>31 HRS</u>	c. CITY OR TOWN <u>MARSHFIELD MO</u>		d. Is Residence within limits of this City or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST JOHNS</u>			e. STREET ADDRESS (If rural, give location) <u>3 MI NORTH MARSHFIELD</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>KAREN</u> b. (Middle) <u>KAY</u> c. (Last) <u>BEAL</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>OCT 17 - 1955</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>OCT 16 - 1955</u>		9. AGE (In years last birthday) Months Days <u>1 31</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>EARL BEAL</u>		13b. MOTHER'S MAIDEN NAME <u>BETTY MCGOON</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>EARL BEAL MARSHFIELD MO</u>		
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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Prematurity</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Congenital Atelectasis</u>				INTERVAL BETWEEN ONSET AND DEATH  <u>7625</u>
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)			
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 <u>10-16</u> , <u>1955</u> , to <u>10-17</u> , <u>1955</u> , that I last saw the deceased alive on <u>10-17</u> , <u>1955</u> , and that death occurred at <u>11:55 P.M.</u> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>Paul Busiek M.D.</u>			23b. ADDRESS <u>Springfield Mo.</u>		23c. DATE SIGNED <u>10-19-55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>10-19-1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>MARSHFIELD</u>	24d. LOCATION (City, town, or county) (State) <u>MARSHFIELD MO</u>		
DATE REC'D BY LOCAL REG. <u>10-21-55</u>	REGISTRAR'S SIGNATURE <u>Earth Williamson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>R.W. BARBER MARSHFIELD</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

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**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.....  
Signature of Student Embalmer

Signed.....  
*Not Embalmed.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.