

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42699

State File No. _____

FILED DEC 18 1956

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10694**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give town or town St. Louis, Mo)		a. STATE Tennessee	b. COUNTY Shelby
c. LENGTH OF STAY (In this place) 47 days		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Frisco Employes Hospital Assn		e. STREET ADDRESS (If rural, give location) 226 South Cleveland	

3. NAME OF DECEASED (Type or Print)	a. (First) Clarence	b. (Middle) Joseph	c. (Last) Beshears	4. DATE OF DEATH (Month) (Day) (Year)
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH 12-2-1883	9. AGE (In years last birthday) 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer	10b. KIND OF BUSINESS OR INDUSTRY Railway	11. BIRTHPLACE (City and State or Foreign Country) Missouri	12. CITIZEN OF WHAT COUNTRY? America	

13a. FATHER'S NAME John	13b. MOTHER'S MAIDEN NAME Susan Webb	14. NAME OF HUSBAND OR WIFE Nell Beshears
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowns) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 702-07-2021	17. INFORMANT'S SIGNATURE AND ADDRESS Frisco Employes Hospital, St. Louis, Mo.

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) Reticulum Cell Sarcoma	II. OTHER SIGNIFICANT CONDITIONS 200.0		2 months
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			
ANTECEDENT CAUSES			
Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last.			
DUE TO (c)			

19a. DATE OF OPERATION 11/3/56	19b. MAJOR FINDINGS OF OPERATION Of Above	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)
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 **10/5/56**, 19**56**, to **11/21/56**, 19**56**, that I last saw the deceased alive on **11/21**, 19**56**, and that death occurred at **6:40A** m., from the causes and on the date stated above.

23a. SIGNATURE Charles H. Wells M.D.	23b. ADDRESS 4960 Laclede St. Louis, Mo	23c. DATE SIGNED 11/21/56
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal.	24b. DATE 11-21-56	24c. NAME OF CEMETERY OR CREMATORY Calvarly
24d. LOCATION (City, town, or county) (State) Memphis, Tennessee	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Albert H. Hoppe, 4700 Washington Blvd.	
DATE REC'D BY LOCAL REG. NOV 23 1956	REGISTRAR'S SIGNATURE Carl Smith Mo	

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

S.

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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 *G. W. Wilkinson*.....

Licensed Embalmer No. *35*.....

P. O. Address *M. L. ...*.....

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.