

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11864

STATE FILE NUMBER

FILED APR 9 - 1957

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 63

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Vernon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Nevada 10820</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital #3 - Nevada</u> Length of stay in 1b <u>18 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>unknown</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>AMY BEATTIE</u> First Middle Last		4. DATE OF DEATH <u>3 26 57</u> Month Day Year	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/26/1899</u>
9. AGE (In years last birthday) <u>78</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	11. BIRTHPLACE (City and state or country) <u>Kansas 1</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jos. Beattie</u>	
14. MOTHER'S MAIDEN NAME <u>Mary de Lamater</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give year or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Records State Hospital #3</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4200</u>			INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY a. m. p. m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>12/31/56</u> to <u>3/26/57</u> and last saw her alive on <u>3/26/57</u> Death occurred at <u>4/4</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>George Esker, M.D.</u>		22b. ADDRESS <u>State Hop #3 - Nevada</u>	
22c. DATE SIGNED <u>3/26/57</u>		23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>	
23b. DATE <u>1957 March 28</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moore Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Nevada</u>		STATE <u>Missouri</u>	
24. FUNERAL DIRECTOR <u>Ferry Funeral Home, Nevada, Mo.</u> ADDRESS		25. DATE REG. BY LOCAL REG. <u>4-3-1957</u>	
26. REGISTRAR'S SIGNATURE <u>Anna J. Ferry</u>			

(Licensed Embalmer's Statement on Reverse Side)

451

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 *L. Angles Ferry*

Licensed Embalmer No. *496*

P. O. Address *Alameda, T.*

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.