

pt. Health,  
, & Welfare  
S. Public  
lth Service

S. 300  
ev. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38945

STATE FILE NUMBER

FILED OCT 29 1957

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 172

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cedar 1</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Twp Rural Nevada</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>El Dorado Spgs</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>East 2 mi on 54 Highway</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>106 W. Broadway</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Roy Alvin Beebe</u>			4. DATE OF DEATH Month Day Year <u>10-18-57</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 3, 1895</u>	9. AGE (In years last birthday) <u>62</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian - M.F.A. Cheese Plant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Sumner Co., Kans.</u>	11. BIRTHPLACE (City and state or country) <u>Kans.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Byron S. Beebe</u>	13b. MOTHER'S MAIDEN NAME <u>Lucinda Hanson</u>	14. NAME OF HUSBAND OR WIFE <u>Opal Riley Beebe</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u>	16. SOCIAL SECURITY NO. <u>544-03-3093</u>	17. INFORMANT <u>Opal Riley Beebe - El Dorado Spgs.</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Myocardial infarction</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary occlusion</u>	
	DUE TO (c) <u>Coronary arteriosclerosis</u>	<u>4201</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a).		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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
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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.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from 9-20-57 to 10-18-57 and last saw him alive on 10-18-57  
Death occurred at 2:10 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Robert L. Granger M.D.</u>	(Degree or title)	22b. ADDRESS <u>El Dorado Springs, Mo.</u>	22c. DATE SIGNED <u>10-21-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>10-24-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Clintonville Cemetery El Dorado Spgs, Mo</u>	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR <u>Swain Brothers El Dorado Spgs, Mo</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>10-23-1957</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. Ferris</u>
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(License of Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1080

51

MAR 24 1958

**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 *Max W. Dickering* .....

Licensed Embalmer No. *4696* .....

P. O. Address *E. D. ...*

**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.**