

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-039818
STATE FILE NUMBER

DEC 8 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5411

5. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> COUNTY <u>Johnson</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Olathe R.R. 1</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Luke's Hosp.</u>		Length of stay in 1b <u>9 days</u>	d. STREET ADDRESS (If outside, give location) <u>6 1/2 mi n.w.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLOYD J. BEAVER</u>			4. DATE OF DEATH Month Day Year <u>11-14-58</u>		
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>2-15-88</u>	9. AGE (In years last birthday) <u>70</u>	FUNDER YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	11. BIRTHPLACE (City and state or country) <u>Council Grove, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>Joseph Beaver</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah DuBois</u>		14. NAME OF HUSBAND OR WIFE <u>Leola Beaver</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>513-18-9192</u>	17. INFORMANT <u>Leola Beaver, Olathe Kan R.R. 1</u> <u>Postoperative</u>		
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>Pulmonary Embolism, massive</u> DUE TO (b) <u>Phlebotrombosis, femoral vein</u> DUE TO (c) <u>Cancer of Colon sigmoid (?) as to cause of thrombosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cancer sigmoid colon, removed by operation 1 day prior to death</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Immediate?</u> <u>Few days?</u>
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.) <u>1533</u>		
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.			20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>11-5-58</u> to <u>11-14-58</u> and last saw him alive on <u>Nov 14 58</u> Death occurred at <u>11-14-58 11 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>L. P. Engel M.D.</u> <u>Dr. John A. Griffith, M.D.</u>			22b. ADDRESS <u>315 Nichols Rd. Kan City Mo</u>		22c. DATE SIGNED <u>11/14/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Nov. 14-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Monticello Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Deloto-Kan. R.R. 1</u>
24. FUNERAL DIRECTOR <u>Ward Harrigan</u>		ADDRESS <u>Romer, Springfield, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>11-15-58</u>	26. REGISTRAR'S SIGNATURE <u>Gene Marshall</u>	

All diseases in Part I must be causally related. No symptoms will be listed.

I. P. Engel by Dr. John A. Griffith, Jr. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *May E. Miller*
Licensed Embalmer No. *4555*
P. O. Address *K.E. 115*

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.