

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-043121  
STATE FILE NUMBER

FILED JAN 5 1958 Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 406

13  
300  
4  
1-57

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Adair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Novinger</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>C. N. H. #1</b>		Length of stay in lb	d. STREET ADDRESS <b>Novinger</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Phillip</b> Last <b>Beatie</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>26</b> Year <b>1958</b>		
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5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 15, 1893</b>	9. AGE (In years 16 (birthday) <b>65</b> )	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) <b>Retired Railroad</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>R. R. Section Div</b>	11. BIRTHPLACE (City and state or country) <b>Henderson Co. Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Thomas P. Beatie</b>	13b. MOTHER'S MAIDEN NAME <b>Mary J. Krohn</b>	14. NAME OF HUSBAND OR WIFE <b>Liousia Haley Beatie, Dec'd.</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>John Beatie, Clara City, Minn.</b>	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: IMMEDIATE CAUSE (a) <b>Medullary failure</b> <b>Cerebrovascular</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>unknown</b>
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"/> <b>2</b>

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.	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 <b>Dec. 22, 1958</b> to <b>Dec 26, 1958</b> and last saw <del>him</del> <sup>her</sup> alive on <b>Dec 25, 1958</b> Death occurred at <b>1:05 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Richard H. Turner, D.O.</b> (Degree or title) <b>2</b>	22b. ADDRESS <b>Kirksville, Mo.</b>	22c. DATE SIGNED <b>12/27/58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/30/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Maple Hills Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kirksville, Mo.</b>
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24. FUNERAL DIRECTOR <b>Chas. R. [unclear]</b> ADDRESS <b>Kirksville, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>12-29-1958</b>	REGISTRAR'S SIGNATURE <b>Doris W. Rathoff</b>
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(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION  
RICHARD H. TURNER, D.O.  
All dispositive Part I must be causally related.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *George W. Davis* .....

Licensed Embalmer No. *4799* .....

P. O. Address *Herbault* .....

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.