

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000920

STATE FILE NUMBER

FILED JAN 12 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 17

Jerry W. Allen, M.B.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield <u>63960</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hospital		Length of stay in 1b 30	d. STREET ADDRESS (If outside, give location) 2055 N. Main Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First DALE Middle G. Last BEACHLER			4. DATE OF DEATH Month January Day 4 Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1924
9. AGE (In years last birthday) 34		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mailer		10b. KIND OF BUSINESS OR INDUSTRY News Paper	11. BIRTHPLACE (City and state or country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME George E. Beachler	
13b. MOTHER'S MAIDEN NAME Dessie Gregg		14. NAME OF HUSBAND OR WIFE Joan Beachler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give WWII or dates of service)		16. SOCIAL SECURITY NO. 494-20-3134	17. INFORMANT Joan Beachler Address Springfield, Missouri
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HODGKINS DISEASE			INTERVAL BETWEEN ONSET AND DEATH ABOUT 5 yrs
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)			19. WAS AUTOPSY PERFORMED? 201X 1 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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
21. I attended the deceased from SEPT 1955 to 1-4-59 and last saw ^{xxxx} him alive on 1-4-59 Death occurred at 7:50PM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Jerry W. Allen M.D.</i> (Deputy or title)		22b. ADDRESS Springfield, Missouri	22c. DATE SIGNED 1-6-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-7-1959	23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	23d. LOCATION (City, town, or county) (State) Springfield, Missouri
24. FUNERAL DIRECTOR J.W. KLINGNER & CO. ADDRESS Spfld, Mo.		25. DATE RECD. BY LOCAL REG. 1-7-59	26. REGISTRAR'S SIGNATURE <i>Effie G. Melton</i>

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JAN 26 1959

JAN 12 1959
JAN 19 1959

APR 8 1959

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 *Mal Hodges*

Licensed Embalmer No. *497*
P. O. Address *Springfield*

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.