

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004533

STATE FILE NUMBER
228

FILED MAR 9 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 228

300
1-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN St. Joseph		c. CITY OR TOWN St. Joseph 0117	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2626 Felix St.		d. STREET ADDRESS (If outside, give location) 2626 Felix St.	
Length of stay in lb 45 years		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MIDDLE Last BETTY FARRELL BECK			4. DATE OF DEATH Month Day Year Feb. 27, 1959		
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5. SEX female	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 Aug. 18, 1900	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months Days	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) housewife	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and state or country) Flag Springs, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME James Farrell	13b. MOTHER'S MAIDEN NAME Ida Fletchall	14. NAME OF HUSBAND OR WIFE A. E. Beck
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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) no	16. SOCIAL SECURITY NO. unknown	17. INFORMANT A. E. Beck, 2626 Felix, St. Joseph, Mo.
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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) Pelvic lymphosarcoma - metastasis (Origin not determined)		INTERVAL BETWEEN ONSET AND DEATH 2 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) 2001		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

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.	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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20d. INJURY OCCURRED WHILE AT <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 11-14-56 to 2-27-59 and last saw her alive on 2-27-59 Death occurred at 11:00a. m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE Robert W. Kieber MD	22b. ADDRESS St. Joseph, Mo	22c. DATE SIGNED 2-28-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 3/2/1959	23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
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24. FUNERAL DIRECTOR Heaton-Bowman	ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Mar 2, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
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Dr. Robert W. Kieber
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.
Doctor, coroner, etc. must use only standard nomenclature in their reports - no symptoms written instead.

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 *William Spalding*

Licensed Embalmer No. *4535*.....

P. O. Address *H. Joseph 210*

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.