

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005350

STATE FILE NUMBER

FILED MAR 2 1959 Registration District No. 142 Primary Registration District No. 5876 Registrar's No. 18

1- PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Shannon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Goldsberry Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Birch Tree</u> 1010
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hosp.</u>		Length of stay in lb <u>12 hours</u>	d. STREET ADDRESS (If outside, give location) <u>Rural Route 2</u>
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Joyce</u> Middle <u>Ann</u> Last <u>Beads</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>17</u> Year <u>1959</u>		
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	18. DATE OF BIRTH <u>Oct. 18-1938</u>	9. AGE (In years) <u>20</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Effingham, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Seland H. Beads</u>	13b. MOTHER'S MAIDEN NAME <u>Alice L. De Vore</u>	14. NAME OF HUSBAND OR WIFE <u>none</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</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Seland Beads Rt 2 Birch Tree, Mo.</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: IMMEDIATE CAUSE (a) <u>Uterine Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>uterine atony</u>	
	DUE TO (c) <u>Pregnancy near term 6756</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Had no prenatal care</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</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.)
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20c. TIME OF INJURY Hour <u>delivered</u> Month <u>11</u> Day <u>18</u> Year <u>59</u> a.m. <u>2:10</u> p.m. <u>11:18</u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Effingham, Illinois</u>	STATE <u>Illinois</u>
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21. I attended the deceased from <u>2/17/59</u> to <u>2/17/59</u> and last saw her alive on <u>2/17/59</u> Death occurred at <u>10 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Harold W. Miller M.D.</u>	22b. ADDRESS <u>Willow Springs Mo</u>	22c. DATE SIGNED <u>2/20/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>2-18-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Blue Point Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Effingham, Illinois</u>
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24. FUNERAL DIRECTOR <u>Duncan Funeral Home Mt. View, Mo</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>2/24/59</u>	26. REGISTRAR'S SIGNATURE <u>Laura Mitchell</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Joe R. Duncan*

Licensed Embalmer No. *4325*

P. O. Address *Mt. View, Mo.*

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.