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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-008284
STATE FILE NUMBER

FILED MAR 30 1959 Registration District No. 002 Primary Registration District No. 5019 Registrar's No. 17

1. PLACE OF DEATH
a. COUNTY: Andrew
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Rochester Township — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Shady Lawn — Length of stay in Ib: 6 mo.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Andrew
c. CITY OR TOWN: Res — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Alfred Middle: M Last: Beattie

4. DATE OF DEATH: Month: March Day: 26 Year: 1959

5. SEX: male **6. COLOR OR RACE**: white **7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐ 2

8. DATE OF BIRTH: Aug. 26, 1874 **9. AGE** (In years last birthday): 84 — 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): retired farmer **10b. KIND OF BUSINESS OR INDUSTRY**: own farm

11. BIRTHPLACE (City and state or country): Island City, Missouri **12. CITIZEN OF WHAT COUNTRY?**: USA

13a. FATHER'S NAME: Joseph S. Beattie **13b. MOTHER'S MAIDEN NAME**: Alice Landers **14. NAME OF HUSBAND OR WIFE**: Cora Alice Beattie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none **17. INFORMANT**: Mrs. Georgia Jackson, Savannah, Mo. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 4200
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Arterio-Sclerotic heart disease with congestive failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 4-26-54, to 3-26-59 and last saw ~~xx~~ him alive on 3-24-59
Death occurred at 1:45 PM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Warren C. Bahn M.D.
22b. ADDRESS: Savannah, Mo.
22c. DATE SIGNED: 3-27-59

23a. BURIAL, CREMATION, REMOVAL (Specify): burial **23b. DATE**: March 28, 1959 **23c. NAME OF CEMETERY OR CREMATORY**: Whitesville Cemetery **23d. LOCATION** (City, town, or county) (State): Whitesville, Missouri

24. FUNERAL DIRECTOR ADDRESS: Breit Funeral Home, Savannah, Mo.
25. DATE RECD. BY LOCAL REG.: 3-28-59
26. REGISTRAR'S SIGNATURE: Lillian Sparks Reg

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 James B. Hawkins

Licensed Embalmer No. 4536

P. O. Address Savannah

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.