

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014583
STATE FILE NUMBER

FILED MAY 5 1959

Registration District No. 316 Primary Registration District No. Registrar's No. 167

300
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY St. Francois			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cape Girardeau		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Township		Ins. Limits Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	c. CITY OR TOWN Jackson Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. State Hospt. #4		Length of stay in lb 4 das.	d. STREET ADDRESS (If outside, give location) 211 W. Mary		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Charles E. Middle Beattie Last Beattie			4. DATE OF DEATH Month April Day 24 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 Sept. 4 1895		9. AGE (In years less birthday) 63 Months 5 Day 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		10b. KIND OF BUSINESS OR INDUSTRY Pressing Co.	11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Joseph W. Beattie		13b. MOTHER'S MAIDEN NAME Christene Kastenbaden		14. NAME OF HUSBAND OR WIFE Irene Beattie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. # 1		16. SOCIAL SECURITY NO. 493-32-9979		17. INFORMANT Address Irene Beattie Jackson Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma of left lung - - - - -					INTERVAL BETWEEN ONSET AND DEATH Abt. 6 mos.
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) Reactive depression.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) 1621		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____					
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	
21. I attended the deceased from April 20, 1959 to April 24, 1959 and last saw him alive on April 24, 1959 Death occurred at 12:03 A. M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) John A. Brennan M.D.			22b. ADDRESS State Hospital No. 4 Farmington, Missouri		22c. DATE SIGNED 4-24-59
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-27-59	23c. NAME OF CEMETERY OR CREMATORY City Cemetary		23d. LOCATION (City, town, or county) (State) Jackson Mo.
24. FUNERAL DIRECTOR ADDRESS Deneke-Laird Jackson Mo.			25. DATE RECD. BY LOCAL REG. Apr. 27, 1959	26. REGISTRAR'S SIGNATURE Ester Rudloff	

All diseases in Part I must be causally related.

MAY 2 1959

MAY 1 1959

MAY 1 1959

MAY 6 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 *R. O. Laird*

Licensed Embalmer No. *4538*

P. O. Address *Jackson, Miss*

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.