

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022210  
STATE FILE NUMBER

REG. JUN 19 1959 Registration District No. 217 Primary Registration District No. 5785 Registrar's No. 49

S. 300  
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Mississippi</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <b>Missouri</b> b. COUNTY <b>Mississippi</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rt. 1 Bertrand</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Rt. 1 Bertrand</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Rt. 1 Bertrand</b>		Length of stay in 1b <b>25 Years</b>	d. STREET ADDRESS <b>Rt. 1 Bertrand</b>		(If outside, give location) Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harrison</b> Middle <b>Dewey</b> Last <b>Beasley</b>			4. DATE OF DEATH Month <b>5</b> Day <b>29</b> Year <b>59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/9/1903</b>	9. AGE (in years last birthday) <b>55</b>	10. FUNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Camden, Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Jacob Beasley</b>		13b. MOTHER'S MAIDEN NAME <b>Mollie Spencer</b>		14. NAME OF HUSBAND OR WIFE <b>Gaynell Bell Beasley</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>489-14-9320</b>	17. INFORMANT Address <b>Mrs. Gaynell Beasley, Rt. 1 Bertrand</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ART. SCLER. HEART DIS.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT</b>	
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) <b>Ess. HYPERTENSION</b>					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.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.						
20d. INJURY OCCURRED WHILE AT WORK <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 Death occurred at <b>MAY 1958</b> to <b>5-29-59</b> and last saw <sup>her</sup> him alive on <b>5-15-59</b> on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>Carl G. Popps M.D.</b>	(Degree or title)	22b. ADDRESS <b>St. Keaton</b>		22c. DATE SIGNED <b>5-30-59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5/31/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Valley Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Gleason, Tenn.</b>			
24. FUNERAL DIRECTOR <b>The Nunnelee Funeral Chapel</b>	ADDRESS <b>Charleston, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>6-12-59</b>	26. REGISTRAR'S SIGNATURE <b>Dorothy B. Hathorn</b>			

VS MAY 24 1960

Date Filed 6-17-69

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 *John F. Nunnally* .....

Licensed Embalmer No. 3851  
P. O. Address Charleston, W

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.