

FILED VS AUG 4 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-024009
STATE FILE NUMBER

Registration District No. 4 Primary Registration District No. _____ Registrar's No. 73

60
S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Atchison</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Atchison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rock-Port mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Rock-Port mo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>0030</u> <u>0</u> Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Irvin U. Beasing</u>			4. DATE OF DEATH Month Day Year <u>July 22 1959</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept-9-1888</u>
9. AGE (In years last birthday) <u>70</u>		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) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME <u>Henry Beasing</u>	
13b. MOTHER'S MAIDEN NAME <u>Carolyn Froh</u>		14. NAME OF HUSBAND OR WIFE <u>Elcie Huffman Beasing</u>	
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. <u>493-18-4896</u>	17. INFORMANT Address <u>Mrs. Elcie Beasing - Rock Port Mo</u>
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>Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary Arteriosclerosis.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</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.) <u>4201</u>	
20c. TIME OF INJURY Hour Month, Day, Year 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 <u>7-22-59</u> to <u>7-22-59</u> and last saw her ^{her} <u>alive</u> on <u>7-22-59</u> Death occurred at <u>2:30 Pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Wallace Carpenter M.D.</u>		22b. ADDRESS <u>Rock Port Mo</u>	22c. DATE SIGNED <u>7-27-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>July 25/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenhill cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Rock-Port mo</u>
24. FUNERAL DIRECTOR <u>Bertram Funeral Home - Rock-Port</u>		25. DATE RECD. BY LOCAL REG. <u>July 29 1959</u>	26. REGISTRAR'S SIGNATURE <u>Therion H. Schaefer</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *C. E. P. ...*

Licensed Embalmer No. *1744*

P. O. Address *Rock Point Md*

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.