

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035582

FILED VS NOV 12 1959 77

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 2016 Registrar's No. 312

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Cole</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Shelps.</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson City, Mo.</u>		Length of stay in 1b <u>92 days.</u>	c. CITY OR TOWN <u>St James,</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial Community Hosp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Republican Road</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GRACE</u> Middle <u>Louise</u> Last <u>Beezley</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>8</u> Year <u>59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>2-6-14</u>	9. AGE (last birthday) <u>45</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>Mineral, Ill.</u>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <u>William G. Bied</u>		13b. MOTHER'S MAIDEN NAME <u>Mabel Leak</u>		14. NAME OF HUSBAND OR WIFE <u>Floy Beezley</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Harriett B. Weiss - Jefferson City, Mo</u> Address <u>708 Washington</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) Epidermoid Carcinoma, gingiva of Mouth, with generalized Metastasis.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____

INTERVAL BETWEEN ONSET AND DEATH
10 Mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)
Postoperative Radical Neck Dissection 8-11-1959.

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

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. _____	Month, Day, Year _____				
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 8-3-1959 to 11-8-59 and last saw her him alive on 11-8-1959
Death occurred at 11-8-59, 6:25 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Tendall P. Clark, M.D.</u>		22b. ADDRESS <u>615 E. High Jefferson City, Mo</u>		22c. DATE SIGNED <u>11-9-59</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/10/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MASONIC ST. JAMES.</u>	23d. LOCATION (City, town, or county) <u>St. James</u>	23e. STATE <u>Mo.</u>	

24. FUNERAL DIRECTOR <u>Sylvester Gulle</u>	ADDRESS <u>JC Mo</u>	25. DATE RECD. BY LOCAL REG. <u>11 November 1959</u>	26. REGISTRAR'S SIGNATURE <u>RP. Davis, MD - Richter</u>		
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 17 1959 SA

JAN 7 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____
Licensed Embalmer No. 4321
P. O. Address J. C. 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.