

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 24 1959

59-040496

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 511

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>INDEPENDENCE</u>		Length of stay in 1b <u>47 YRS</u>		c. CITY OR TOWN <u>INDEPENDENCE</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>804 So. Woodland</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>804 So. Woodland</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BESSIE BEALS</u>				4. DATE OF DEATH Month Day Year <u>Nov 16, 1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-28-79</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>INDEPENDENCE, INDIANA</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>C. W. Titus</u>		13b. MOTHER'S MAIDEN NAME <u>ELLEN Foster</u>		14. NAME OF HUSBAND OR WIFE <u>OSCAR T. BEALS</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>NONE</u>		17. INFORMANT Address <u>FLORENCE E. GRAHAM INDEP. 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 Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Congestive Heart Failure</u>						<u>Several Years</u>	
DUE TO (c) <u>Pneumonia - Bronchial</u>						<u>24-48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I <u>Fractured Hip 3-13-59 - Hypertension</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 Month, Day, Year 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 <u>7-11-58</u> to <u>11-16-59</u> and last saw her alive on <u>11-16-59</u> Death occurred at <u>12:30p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>D. Frederick A. Treffer, D.O.</u>				22b. ADDRESS <u>5518 Truman Rd KC 27 Mo</u>		22c. DATE SIGNED <u>11-16-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-19-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		23d. LOCATION (City, town, or county) (State) <u>INDEPENDENCE, Mo.</u>	
24. FUNERAL DIRECTOR <u>ROLAND R. SPEAKS</u>				ADDRESS <u>INDEP. Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-19-59</u>	
				26. REGISTRAR'S SIGNATURE <u>Frederick A. Treffer</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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

*Rollie Fessel*

Licensed Embalmer No. 4690

P. O. Address Indep. 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.