

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-045116

FILED VS DEC 19 1961

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 689

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Crawford</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>89 days</u>	c. CITY OR TOWN <u>Cherryville</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>Ellis Fischel State Cancer</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Cherryville</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur Wallace Beard</u>			4. DATE OF DEATH Month Day Year <u>Dec. 10, 1960</u>			
5. SEX <u>Male</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>3-28-05</u>	9. AGE (last birthday) <u>55</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>Not known</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Day laborer</u>		11. BIRTHPLACE (City and state or country) <u>Leeper, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Bud Beard</u>		13b. MOTHER'S MAIDEN NAME <u>Zoe Odell</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Ollie Beard</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>497-09-3401</u>		17. INFORMANT Address <u>Hospital Records.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>CEREBRAL ABSCESS, RIGHT</u>			<u>25 DAYS</u>
DUE TO (b) <u>RIGHT CAROTID OCCLUSION, WITH PROBABLE SEPTIC THROMBOSIS</u>			<u>25 "</u>
DUE TO (c) <u>ACUTE GANGRENE OF NECK SKIN FLAPS</u>			<u>71 "</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>STATUS POST OP. TOTAL LARYNGECTOMY & RIGHT RADICAL NECK</u> <u>72 DAYS DISESECTION FOR EPIDERMOID CARCINOMA OF LARYNX</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 s.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>10-1-60</u> to <u>12-10-60</u> and last saw him alive on <u>12-10-60</u> Death occurred at <u>845</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>Robert F. Treagan, MD</u>		22b. ADDRESS <u>40 AND GARTH Columbia Mo</u>		22c. DATE SIGNED <u>12-10-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-11/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Piedmont Cern</u>	23d. LOCATION (City, town, or county) (State) <u>Piedmont - Mo</u>	
24. FUNERAL DIRECTOR <u>Zelbunde</u>		ADDRESS <u>Columbia Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Dec 11, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mrs RE Palmer</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 20 1968

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

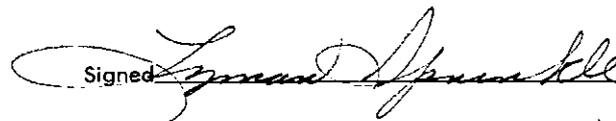
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed



Licensed Embalmer No. 4613

P. O. Address Columbia

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.