

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035930

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1036

STATE FILE NUMBER

FILED OCT 23 1961

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u> | | Length of stay in 1b <u>72 Years</u> | c. CITY OR TOWN <u>St. Joseph</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>Meth. Hosp. & Med. Cen.</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>511 South 16th St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | |
|--|---|
| 3. NAME OF DECEASED (Type or print) First <u>Rufus</u> Middle <u>Preston</u> Last <u>Beshears</u> | 4. DATE OF DEATH Month <u>October</u> Day <u>10</u> Year <u>1961</u> |
|--|---|

| | | | | | | |
|-----------------------|----------------------------------|---|--|-------------------------------------|--|--|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</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>Oct. 12, 1888</u> | 9. AGE (last birthday) <u>72</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> |
|-----------------------|----------------------------------|---|--|-------------------------------------|--|--|

| | | | |
|--|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Dental Surgery</u> | 11. BIRTHPLACE (City and state or country) <u>St. Joseph, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
|--|--|--|--|

| | | |
|---|--|---|
| 13a. FATHER'S NAME <u>Strothers Beshears</u> | 13b. MOTHER'S MAIDEN NAME <u>Georgia Lanier</u> | 14. NAME OF HUSBAND OR WIFE <u>Mrs Kelsy B. Beshears</u> |
|---|--|---|

| | |
|---|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WW I</u> | 17. INFORMANT <u>511 South 16th Street</u> <u>Mrs Kelsy B. Beshears, City</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 <u>6 days</u> |
| IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> | | |
| CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | |
| DUE TO (b) <u>Multiple myeloma</u> | | |
| DUE TO (c) <u>arterio-sclerosis with left heart failure 3-4 years</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | 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 |

| | | |
|---|---|--|
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u> </u> a.m. <u> </u> p.m. <u> </u> | 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 Feb 1960 to 10-10-61 and last saw him alive on 10-10-61
Death occurred at 11:30 p m on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|---|---|-------------------------------------|
| 22a. SIGNATURE <u>Lucien W. Ide M.D.</u> (Degree or title) | 22b. ADDRESS <u>702 Edward St. Joseph, Mo.</u> | 22c. DATE SIGNED <u>10-13-61</u> |
|---|---|-------------------------------------|

| | | | |
|--|---------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Oct. 14-'61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Ashland Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u> |
|--|---------------------------------|---|---|

| | | |
|---|--|--|
| 24. FUNERAL DIRECTOR <u>Wm. H. Alexander</u> ADDRESS <u>St. Joseph, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>Oct. 17, 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u> |
|---|--|--|

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION
L. W. Ide, M.D.

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 Wm. H. Alexander

Licensed Embalmer No. 4450

P. O. Address St. Joseph, 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.