

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-003463

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318-3302286

SL 241003

1224

STATE FILE NUMBER

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED FEB 7 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY Richland	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Length of stay in 1b 12 DAYS	c. CITY OR TOWN OLNEY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET ADM HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 930 W. ELM STREET Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last ROBERT DENNY BEAL			4. DATE OF DEATH Month Day Year JANUARY 27, 1962		
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5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-13-12	9. AGE (last birthday) 49	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOWLING LANES PROP.	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and state or country) LOUISVILLE, ILLINOIS	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME ISAAC G. BEAL	13b. MOTHER'S MAIDEN NAME FLORENCE C. LANCASTER	14. NAME OF HUSBAND OR WIFE ANGELINE M. BEAL
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWII	16. SOCIAL SECURITY NO.	17. INFORMANT Address ANGELINE M. BEAL, SEE # 2d
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH ? DAYS
DUE TO (b) HEPATIC COMA		2 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) LANEC'S CIRRHOSIS 58/1		YEARS

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
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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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21 VA attended the deceased from **1-15-62** to **1-27-62** and last saw ~~him~~ ^{her} alive on **1-27-62**
Death occurred at **11:35 p.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Julian C. Wallace, M.D.	22b. ADDRESS VAH, ST. LOUIS, MO.	22c. DATE SIGNED 1-28-62
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-29-62	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Olney, Ill.
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24. FUNERAL DIRECTOR ADDRESS Robert Schaub, Olney, Ill.	25. DATE RECD. BY LOCAL REG. JAN 29 1962	26. REGISTRAR'S SIGNATURE Loed Smith, M.D.
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

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

John J. Kessly III
Signed _____
Licensed Embalmer No. 5039
P. O. Address E. W. Lewis Sec

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.