

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-017849

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 173

FILED JUN 11 1962

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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3017

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

Beale

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Adair | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY ADAIR | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Kirksville | | Length of stay in lb yrs | c. CITY OR TOWN Kirksville Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR KIRKSVILLE Kirksville Osteopathic | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1208 S. Baird Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle WILLIAM Last BALES | | 4. DATE OF DEATH Month June Day 2 Year 1962 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 10/19/85 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer | | 10b. KIND OF BUSINESS OR INDUSTRY farming | 9. AGE (last birthday) 76 |
| 11. BIRTHPLACE (City and state or country) Davis Co., Iowa | | 12. CITIZEN OF WHAT COUNTRY U S | |
| 13a. FATHER'S NAME Albert Bales | | 13b. MOTHER'S MAIDEN NAME Grace Clausen | |
| 14. NAME OF HUSBAND OR WIFE Bessie Bales | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | |
| 16. INFORMANT Bessie Bales, Kirksville, Mo. | | 17. ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Strokes (Ventricular Fibrillation) DUE TO (b) Chronic Congestive Failure DUE TO (c) Advanced Coronary Arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH 3 mo Years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Arteriosclerosis of the Heart - Pneumonia Right Lung | | | 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 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 1960 to June 1, 1962 and last saw her/him alive on June 1, 1962 Death occurred at 9:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Alvin W. Beale MD | | 22b. ADDRESS 504 H Kirksville Mo 6304 | 22c. DATE SIGNED |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 6/4/62 | 23c. NAME OF CEMETERY OR CREMATOR Rouch | 23d. LOCATION (City, town, or county) (State) Davis County, Iowa |
| 24. FUNERAL DIRECTOR Foster Memorial Home, Kirksville, Mo. | | 25. DATE RECD. BY LOCAL REG. June 4, 1962 | 26. REGISTRAR'S SIGNATURE Doris W. Rathoff |

Permit Renewed June 4, 1962

JUN 13 1962

DAVID W. BOONE, D.O.

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 *Nova E. Foster*

Licensed Embalmer No. 4742

P. O. Address Kennett, 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.