

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-039780**

**FILED VS. NOV 23 1959**

STATE FILE NUMBER

Registration District No. 137 Primary Registration District No. 3 & 23 Registrar's No. 285-

MEMORANDUM

1. PLACE OF DEATH a. COUNTY <u>Henry Forrest nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton mo Clinton</u>		c. CITY OR TOWN <u>Huntingdale mo</u>	
Length of stay in lb <u>3 weeks</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Forrest nursing Home</u>		d. STREET ADDRESS (If outside, give location)	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Jackson</u> Middle <u>James</u> Last <u>Beaty</u>			4. DATE OF DEATH Month <u>11</u> Day <u>17</u> Year <u>1959</u>				
5. SEX <u>male</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>11-21-1875</u>	9. AGE (last birthday) <u>84 yrs</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>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Henry, Co</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Benjamin Beaty</u>		13b. MOTHER'S MAIDEN NAME <u>Louisa Kinnard</u>		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			

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 hrs</u> <u>6 Wks</u> <u>—</u>
IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)	DUE TO (b) <u>cerebral hemorrhage</u>	
DUE TO (c) <u>arteriosclerosis.</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 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 _____ 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 10-2-59 to 11-17-59 and last saw her alive on 11-16-59  
Death occurred at 12:45 P on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) <u>R.P. Powell MD</u>		22b. ADDRESS <u>Clinton mo</u>		22c. DATE SIGNED <u>11-18-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>11-19-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Unich Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Unich Henry mo</u>	
24. FUNERAL DIRECTOR <u>Brown and Graham Unich mo</u>		25. DATE RECD. BY LOCAL REG. <u>Nov: 19-1959</u>		26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 25 1959

FEB 23 1960

**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 P. R. Kenney

Licensed Embalmer No. 3099

P. O. Address Clinton 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.