

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

24046

313

1. PLACE OF DEATH

County

St. Francis

Registration District No.

224

File No.

Township

Primary Registration District No.

4465

Registered No.

City

Flat River

(No.

St.

Ward)

2. FULL NAME

Allie Ann Beatty

(a) Residence. No.

St.

Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF
(OR) WIFE OF

C.F. Beatty

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Apr 6th 1870

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, ____ hrs.
or ____ min.

61

1

1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

Housewife

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Kentucky

10. NAME OF FATHER

Wm Shoemaker

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Holland

12. MAIDEN NAME OF MOTHER

Elizabeth Stokes

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Kentucky

14.

INFORMANT
(Address)C.F. Beatty
near Esther no.

15.

Date

6/30, 1936

C. B. Harris

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

June 7, 1936

17.

I HEREBY CERTIFY, That I attended deceased from

Jan. 25, 1936, to June 6, 1936.

that I last saw him alive on Jan. 25, 1936, and that death occurred, on the date stated above, at 2:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cardiac failure due to long
and debilitating disease

(duration) yrs. 4 mos. 11 ds.

CONTRIBUTORY Chronic myocarditis, nephritis, Chr.
(SECONDARY) arterial sclerosis, aortic regurgitation, chronic bronchitis
(duration) yrs. 10 mos. 11 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? History & Physical Exam

(Signed)

Paul J. Jones

M. D.

(Address)

Flat River, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Barkwood Cemetery

6/4/36

20. UNDERTAKER

ADDRESS

Caldwell Bros Flat River

Mo.

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No.....
 City..... (No.)..... St..... Word.....

2. FULL NAME

(a) Residence, No..... St..... Word.....
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX..... 4. COLOR OR RACE..... 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. If MARRIED, WIDOWED, OR DIVORCED
 HUSBAND OF (or) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from that I last saw him, alive on....., 19....., to....., 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

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