

S. No. 2  
-1-4-41  
5-17-39  
I X26390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 1908

FILED FEB 19 1942

Registration District No. 135

Primary Registration District No. 5188

Registrar's No. 154

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

700

1. PLACE OF DEATH:

(a) County Carroll  
(b) City or town Rural "Carrollton Sup"  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community about 40 yrs (Specify whether \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll  
(c) City or town Rural "17"  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Florence Beaty

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Fe / 5. Color or race W 6. (a) Single, widowed, married, divorced widow  
6. (b) Name of husband or wife John Beaty 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July 29 1888  
(Month) (Day) (Year)

8. AGE: Years 53 Months 5 Days 24 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Chariton Co. Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

12. Name Wm P Littleton

13. Birthplace Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Eliz Jane Littleton

15. Birthplace Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Robt. Harves

(b) Address Carrollton Mo

17. (a) Burial (b) Date thereof 1-24-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cape Hill Cem

18. (a) Signature of funeral director Stanley Carrollton Mo

(b) Address \_\_\_\_\_

19. (a) 1-23-42 (b) Mrs Janie R. Kaffely  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 23  
year 1942 hour 12 minute 01 A.M.

21. I hereby certify that I attended the deceased from January 18  
1942 to January 23 1942,  
that I last saw her alive on January 20 1942,  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the Uterus  
Duration 2 yrs

Due to \_\_\_\_\_  
Due to 48 hr

Other conditions Chronic myocarditis of several years duration  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN  
\_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature John H. Flatz M.D. (M. D. correct)  
Address Carrollton, Missouri Date signed 1-23-42

RECEIVED

District Health Officer No. 8

of file number

DATE

3-17-42

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signature

*Ben W. Gibson*

Licensed Embalmer No.

2961

P. O. Address

*Carrollton 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 this body is not embalmed, fact should be so stated above.