WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County ~~Cole~~ Moniteau

Township ~~Maries~~ Walker Registration District No. ~~211~~, 571 File No. 2 35782

or Village

Primary Registration District No. 5769 Registered No. (20) 64

or City (NO. St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Emily Francis Beckman

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: June (Month) 20 (Day), 1909 (Year)

AGE: 10 yrs. 11 mos. 2 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION (a) Trade, profession, or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer): attending school

BIRTHPLACE (City or town, State or foreign country): Moniteau Co Mo

PARENTS

NAME OF FATHER: Henry Beckman

BIRTHPLACE OF FATHER (City or town, State or foreign country): Moniteau Co Mo

MAIDEN NAME OF MOTHER: Elizabeth Fahrni

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Switzerland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Beckman

(ADDRESS) McGirk - Mo

Filed 10-21, 1917. ~~Jos. N. Smith~~ J. P. Burke, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct (Month) 20 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 20, 1917, to Oct 20, 1917, that I last saw her alive on Oct 20, 1917, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) 01 yrs. one mos. - ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) M. D.

Oct 21, 1917 (Address) [illegible]

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: [illegible] Cemetery

DATE OF BURIAL: Oct 22, 1917

UNDERTAKER: J. B. Garnett & Son

ADDRESS: California Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County ____________

Township ____________ Registration District No. ____________ File No. ____________

or

Village ____________ Primary Registration District No. ____________ Registered No. ____________

or

City ____________ (NO. ____________ St.; ____________ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME ____________

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
SEX ____ COLOR OR RACE ____ SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word) ____	DATE OF DEATH ____________ (Month) ____ (Day), *191*____ (Year)
DATE OF BIRTH ____________ (Month) ____ (Day), *1*____ (Year)	I HEREBY CERTIFY, that I attended deceased from ____________, 191____, to ____________, 191____,
AGE ____ yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. or ____ min.?	that I last saw h____ alive on ____________, 191____, and that death occurred, on the date stated above, at ____ m.
OCCUPATION (a) Trade, profession, or particular kind of work ____________	The CAUSE OF DEATH* was as follows:
(b) General nature of industry, business, or establishment in which employed (or employer) ____________	____________
BIRTHPLACE (City or town, State or foreign country) ____________	____________ (Duration) ____ yrs. ____ mos. ____ ds.
PARENTS — NAME OF FATHER ____________	Contributory (SECONDARY) ____________ (Duration) ____ yrs. ____ mos. ____ ds.
PARENTS — BIRTHPLACE OF FATHER (City or town, State or foreign country) ____________	(Signed) ____________ M. D. ____________, 191____ (Address) ____________
PARENTS — MAIDEN NAME OF MOTHER ____________	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
PARENTS — BIRTHPLACE OF MOTHER (City or town, State or foreign country) ____________	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE	Where was disease contracted if not at place of death? ____________
(Informant) ____________	Former or usual residence ____________
(ADDRESS) ____________	PLACE OF BURIAL OR REMOVAL ____________ DATE OF BURIAL ____________, 191____
Filed ____________, 191____, ____________ REGISTRAR	UNDERTAKER ____________ ADDRESS ____________