

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045240
STATE FILE NUMBER

FILED JAN 6 1958 Registration District No. 297 Primary Registration District No. 6022 Registrar's No. 1

300
1-57

1. PLACE OF DEATH a. COUNTY Ray		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Ray	
b. CITY (If outside corporate limits, give TOWNSHIP only) Richmond Township		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Richmond ⁰⁸⁹⁰
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION R.F.D. #4		Length of stay in lb Lifetime	d. STREET ADDRESS (If outside, give location) R.F.D. #4
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Wanda Middle Elaine Last Bellis			4. DATE OF DEATH Month 12 Day 29 Year 58		
---	--	--	--	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/14/1956	9. AGE (In years last birthday) 2	IF UNDER 1 YEAR Months 9 Days 15	IF UNDER 24 HRS. Hours Min.
-------------------------	----------------------------------	---	--------------------------------------	---	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (City and state or country) Excelsior Springs, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
---	---	---	--

13a. FATHER'S NAME Harry Bellis	13b. MOTHER'S MAIDEN NAME Mabel Starling	14. NAME OF HUSBAND OR WIFE None
---	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Harry Bellis	Address Richmond, Missouri
--	--	--------------------------------------	--------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Influenza -		INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 _____ o.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <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 Richmond, Mo.	COUNTY Ray	STATE Missouri
---	---	--	--	----------------------	--------------------------

21. I attended the deceased from 4-22-57 to 12-29-58 and last saw her alive on 12-27-58 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.		
--	--	--

22a. SIGNATURE Thomas B. Goff, M.D.	(Degree or title)	22b. ADDRESS Richmond, Mo.	22c. DATE SIGNED 12/30/58
---	-------------------	--------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/31/58	23c. NAME OF CEMETERY OR CREMATORY Richmond Memory Garden	23d. LOCATION (City, town, or county) (State) Richmond, Missouri
--	------------------------------	---	--

24. FUNERAL DIRECTOR Quest-Life Funeral Home	ADDRESS Richmond, Missouri	25. DATE RECD. BY LOCAL REG. 1-3-1959	26. REGISTRAR'S SIGNATURE Mabel Gaskarn
--	--------------------------------------	---	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 10. No symptoms will be stated. All diseases in Part I must be causally related.

73
0

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 *Morris D. Bailey*

Licensed Embalmer No. *4887*

P. O. Address *Richmond, Va.*

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.