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: Lawrence

Township: ____ or Village: ____ or City: Pierce City (NO. ____ St.; ____ Ward)

Registration District No. 471 Primary Registration District No. 4 8 8 14

File No. 18447-A

Registered No. 107

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

FULL NAME Jake Bellm

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

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

DATE OF BIRTH: Feb (Month) 7 (Day), 1873 (Year)

AGE: 43 yrs. 3 mos. ____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country): Illinois

PARENTS
NAME OF FATHER: Charles Bellm
BIRTHPLACE OF FATHER (City or town, State or foreign country): Germany
MAIDEN NAME OF MOTHER: Dont know
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Dont know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joe Bellm

(ADDRESS) Pierce City Mo

Filed May 8 1916. J. W. Bennett
Co. Med. Sub-REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 7 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. 14, 1916, to May 6, 1916, that I last saw him alive on May 5, 1916, and that death occurred, on the date stated above, at 10 A.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

92A (Duration) ____ yrs. 3 mos. 2 ds.

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

(Signed) E. B. Wright M. D.

May 7, 1916 (Address) Pierce City Mo

*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: Pierce City Mo

DATE OF BURIAL: May 8th 1916

UNDERTAKER: John Seufert

ADDRESS: Pierce City Mo

Revised United States Standard Certificate of Death

MISSOURI STATE BOARD OF
BUREAU OF VITAL STATIST
CERTIFICATE OF DEATH

PLACE OF DEATH

County .....

Township .....
or
Village .....
or
City ..... (NO. ..... St.: ..... Ward)

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

[If d
hospit
give i
of stre

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... , 1 .....
(Month) (Day) (Year)

AGE

..... yrs. ..... mos. ..... ds.

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

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

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ..... , 191..... , ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH .....
(Month) (

I HEREBY CERTIFY, that I attended d
..... , 191..... , to .....
that I last saw h ..... alive on .....
and that death occurred, on the date stated above,
The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mo

Contributory .....
(SECONDARY)

..... (Duration) ..... yrs. ..... mo

(Signed) .....

..... , 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Viole
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicida

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, T
RECENT RESIDENTS)

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

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF B
UNDERTAKER	ADDRESS