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.

PLACE OF DEATH

County Monroe

Township South Fork
or
Village
or
City (NO. , St.; Ward)

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

Registration District No. 586 File No. 1625

Primary Registration District No. 0784 Registered No. 1

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

FULL NAME Grimley Lee Bell

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	Negro	Married

DATE OF BIRTH Dec. (Month) 9 (Day), 1893 (Year)

AGE 27 yrs. 1 mos. 9 ds. If LESS than 1 day, hrs. or min.?

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

BIRTHPLACE (City or town, State or foreign country) Audrain County, Mo.

PARENTS
NAME OF FATHER Jasper Bell
BIRTHPLACE OF FATHER (City or town, State or foreign country) Audrain County, Mo.
MAIDEN NAME OF MOTHER Pinkey Trumble
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Monroe County, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Bolden
(ADDRESS) Strother Mo

Filed Jan 20, 1921 (Miss) Effie Drake REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH January (Month) 18 (Day), 1921 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. 18, 1921, to Jan. 18, 1921, that I last saw him alive on (arrived after death) 191, and that death occurred, on the date stated above, at 10:00 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) a few minutes yrs. mos. ds.

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

(Signed) H. F. Betts M. D.

Jan. 19, 1921 (Address) Santa Fe, 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	DATE OF BURIAL
Pleasant Hill, Monroe Co. Mo	Jan. 20, 1921
UNDERTAKER Frank Snyder	ADDRESS Santa Fe, Mo.

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE 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

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OF 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

....., *191*.....
(Month) (Day) (Year)

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

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory .....
(SECONDARY)

.....(Duration).....yrs. .....mos. .....ds.

(Signed) ..... M. D.

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

*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	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS

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.