

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

Do not use this space.

19544

399

1. PLACE OF DEATH

County Jackson
Township Raw
City K. C. Mo. (No. 1018 Belfountain)

Registration District No. 1002
Primary Registration District No. 1002

File No. _____
Registered No. 2544
St. _____ Ward _____

2. FULL NAME

Robert Wm Bellings
(a) Residence. No. 1018 Belfountain Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE Wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May - 10 - 30

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
✓ 1 05

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Sehies
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) K. C. Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Joseph Bellings

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mass.

12. MAIDEN NAME OF MOTHER Anna Langton

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) N. Y.

14. INFORMANT Mrs Ann Bellings
(Address) 1018 Belfountain

15. FILED 1/19, 19 30 M. M. Brown REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6 - 18 19 30

17. I HEREBY CERTIFY, That I attended deceased from 6-18-30 to 6-18-30, 1930 that I last saw him alive on 6-18-30, 1930, and that death occurred, on the date stated above, at 9 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho-Pneumonia
107A
150
(duration) yrs. mos. ds. one

CONTRIBUTORY (SECONDARY) Malnutrition
(duration) yrs. mos. ds. 1 18

18. WHERE WAS DISEASE CONTRACTED 1000
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF 2

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? ✓
(Signed) W. K. Fowler M. D.
6/19, 19 30 (Address) 1529 Foster

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Leeds. DATE OF BURIAL 6-19-30

20. UNDERTAKER O. H. Mack ADDRESS K6 Mo

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.

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

