

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

Do not use this space.

38337

File No. _____
Registered No. 290 _____
St. _____ Ward) _____

1. PLACE OF DEATH

County Vernon Registration District No. 875
Township _____ Primary Registration District No. 6162
City _____ (No. _____ St. _____ Ward) _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward. _____
(Usual place of abode) _____ (If nonresident, give city or town and State)
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.

John C Bell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Amanda Bell
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 18 1861
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 69 - -
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) mo

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) unknown

14.

INFORMANT State Hospital Record
(Address) Madison

15.

FILE NO. 12-10-1930 REGISTRAR E. R. King

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 4 1930

17. I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to Nov 4, 1930, that I last saw him alive on Nov 3, 1930, and that death occurred, on the date stated above, at 5:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute dilatation of heart
(duration) _____ yrs. _____ mos. 3 ds.
CONTRIBUTORY Chronic myo carditis
(SECONDARY) (duration) 5 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) E. H. Coon M. D.

11-4, 1930 (Address) Madison Mo

*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

State Hosp # 3 DATE OF BURIAL 11-10-1930

20. UNDERTAKER

Albert Hays of Nevada Mo. ADDRESS _____

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.

Mrs Amanda Bell.
Cory, Ill.