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

SEP 10 1934

Do not use this space.

1. PLACE OF DEATH
County Carroll — Registration District No. 138 — File No. 23614
Township — Primary Registration District No. 4078 — Registered No. 63
City Norborne (No. ..... St. ..... Ward)

2. FULL NAME Mrs Medora F. Bell
(a) Residence. No. ..... St., ... Ward. (If nonresident, give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William H. Bell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 17, 1854

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
80	1	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis, Mo.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER David Frazier
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Amy Jane Patterson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Missouri

14. INFORMANT Mrs French
(Address) Norborne Mo

15. FILED 7-18, 1934 B. C. Cole M. D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 17 1934

17. I HEREBY CERTIFY, That I attended deceased from July 15th, 1934, to July 17th, 1934 that I last saw her alive on July 17th, 1934, and that death occurred, on the date stated above, at 1.00 P. M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Probably Softening of Brain
(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY) Senile Insanity
(duration) 3 or 4 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) W. A. Dearing, M. D.
, 19 (Address) Norborne

*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: Calvary Cem. at Corder — DATE OF BURIAL: July 18 1934

20. UNDERTAKER: W. T. Stroud — ADDRESS: Norborne Mo

#2 Carroll

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

53

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Mrs. Medora F. Bell

Who died at _____ on July - 17 - 1934

Residence: No. _____ St. _____

(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex F Color or race W ~~Single, married~~, widowed ~~or divorced~~: _____

Date of birth _____ Age: Years 80 Months 1 Days 0

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____

(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Probably softening of brain

(~~No other cause can be ascertained Other than Senile Insanity, No History Available~~)

Other contributory causes of importance Senile Insanity

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____

(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar B. C. Cale, M.D. Date filed

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

Reg. Dist. No. 138

Primary Reg. Dist. No. 4078.

E. T. McGaugh, M.D.

Special Agent.

S-33614