

REC'D MAY 10 1938

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

15552

Do not use this space.

## 1. PLACE OF DEATH

(a) County Shelby Registration District No. 678  
(b) Township St James Primary Registration District No. 5904 Registered No. 55  
(c) City..... (d) Street No.....  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

Edith M Bell 400  
(a) Residence, No. .... St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF .....

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 4 - 1933

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
5 yrs — 22

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none  
9. Industry or business in which work was done, as saw mill, bank, etc. ....  
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation —

12. BIRTHPLACE (CITY OR TOWN) Seaton (STATE OR COUNTRY) mo

FATHER 13. NAME Austin Bell  
14. BIRTHPLACE (CITY OR TOWN) Seaton (STATE OR COUNTRY) mo

MOTHER 15. MAIDEN NAME Blanch Fink  
16. BIRTHPLACE (CITY OR TOWN) Flat (STATE OR COUNTRY) mo

17. INFORMANT (ADDRESS) Austin Bell  
Seaton mo

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Bell cem DATE 4-1 1938

19. FUNERAL DIRECTOR W E Kuehler  
(ADDRESS) St James 310

20. FILED 4-15- 1938 Mo. W. Hour  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-30 1938

22. I HEREBY CERTIFY, That I attended deceased from 3/11 1938, to 3/30 1938  
I last saw her alive on 3/30 1938 Death is said to have occurred on the date stated above, at 8 P m.  
The principal cause of death and related causes of importance were as follows:  
Myocardial Heart Break Date of onset 1/8/38

Other contributory causes of importance  
Chronic Phlebitis  
Both Sides

Name of operation Operation Date of 3/24-  
What test confirmed diagnosis? Rayden Was an autopsy? .....

23. 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

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify —  
(Signed) E. E. Scott, M. D.  
(Address) St James Hospital, St James Mo

93A1

STATEMENT BY LICENSED EMBALMER

I, Orvil E. Licklider, Licensed Embalmer No. 3546

hereby certify that the body recorded on the reverse side of this certificate was embalmed by himself

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed Orvil E. Licklider  
Licensed Embalmer No. 3546

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

15552  
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1. PLACE OF DEATH

(a) County Delphs Registration District No. 678  
 (b) Township James Primary Registration District No. 5904  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Edith M. Bell

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S  
(Write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
5 0 22

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_, 19\_\_

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-30, 1938

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_ to \_\_\_\_\_, 19\_\_

I last saw him alive on \_\_\_\_\_, 19\_\_ Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

myocardial heart  
stroke 1862  
 Date of onset

Other contributory causes of importance:  
Pleuritic effusion  
both sides  
by falling on stairs the month  
preceding to my care  
 Name of operation \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Accid. Date of injury 3-28, 1938

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 Home - Fall -  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_

(Signed) E. G. Scott, M. D.

(Address) James

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SAMPLE

15552