

REC'D MAY 10 1939

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

14011
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Raw Primary Registration District No. 1092
 (c) City R.C. Mo. (d) Street No. General Hospital #2 Registered No. 1765
 (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

Infant Tyrone Bell
 (a) Residence, No. 7521 Grand 3rd fl. St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE Colored 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) 1-31-39
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 2 8 24
 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) (STATE OR COUNTRY) Mo

FATHER 13. NAME Eugene Beverly
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Margaret Bell
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Okla.

17. INFORMANT Record Clerk
 (ADDRESS) General Hosp.

18. BURIAL, CREMATION, OR REMOVAL Head Mo DATE Apr. 28, 1939

19. FUNERAL DIRECTOR West of Clinton
 (ADDRESS) 1905 - Wade Ave

20. FILED Apr 27, 1939 M. M. Brown
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-24-1939
 22. I HEREBY CERTIFY, That I attended deceased from 2-27, 1939 to 4-24, 1939
 I last saw him alive on 4-24, 1939. Death is said to have occurred on the date stated above, at 3:05 p.m. a.m.
 The principal cause of death and related causes of importance were as follows:

Congenital Hydrocephalus (P.O.) 157a
 Date of onset

Other contributory causes of importance:
Respiratory & Circulatory Collapse.

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no

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?
 If so, specify _____
 (Signed) J. C. Purves M. D.
 (Address) General Hospital #2

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.

50M-7-20-37
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STATEMENT BY LICENSED EMBALMER

I, Licensed Embalmer No.

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

..... L. E.

No. or by Registered Apprentice No.

working under my personal supervision.

Signed *EW Went*

Licensed Embalmer No. *2710*

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.)