

JAN 7 1939 135
Registration District No. _____

Primary Registration District No. 3010

Registrar's No. 152

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Carrollton, Mo.
(c) Name of hospital or institution: South Side Hospital
(d) Length of stay: In hospital or institution 29 Days
In this community life

3. (a) PRINT FULL NAME Emily E. Belt 430
8. (b) If veteran, name war no. 8. (c) Social Security No. no.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife E. O. Belt 6. (c) Age of husband or wife if alive 39 years
7. Birth date of deceased: April 29 1860

8. AGE: Years 79 Months 7 Days 28 hr. _____ min. _____
If less than one day _____

9. Birthplace: Brookfield, Mo. State Mo.

10. Usual occupation House work

11. Industry or business at home
12. Name Joseph Mayer
13. Birthplace Bedwin, Kansas
14. Maiden name Barbara Fowler
15. Birthplace Germany

16. (a) Informant's own signature Mae Meek
(b) Address Marborne, Mo.

17. (a) burial (b) Date thereof 12-28-1939
(c) Place: burial or cremation Fairhamer Cemetery

18. (a) Signature of funeral director John Reitch
(b) Address Marborne, Mo.

19. (a) 12/27-39 (b) W. H. Haskins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Carroll
(c) City or town Marborne
(d) Street No. _____
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 26
year 1939 hour 3:30 minute P. M. 12
21. I hereby certify that I attended the deceased from Nov-27
1939, 1939 to Dec 26, 1939;
that I last saw her alive on 12-26, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma Liver - Primary
Due to and great omentum
metastasis - (undetected)
Due to _____
Other conditions: 46
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) _____
(e) Means of Injury _____
23. Signature W. H. Haskins (M. D. or other) _____
Address Carrollton, Mo. Date signed 12/27-39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

FORM 1 X1931

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11/9/40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed *John G. Ditch*

Licensed Embalmer No. *3654*

P. O. Address *Yorkton Mo.*

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.)

If this body is not embalmed, above space should be left blank.