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FILED MAR 18 1940

Registration District No. 1177 Primary Registration District No. 6142 Registrar's No. \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Texas  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
~~XXXXXX~~  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution All her life  
In this community All her life  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Mary Bell 400

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Will Bell 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct. 17th, 1851  
(Month) (Day) (Year)

8. AGE: Years 89 Months 3 Days 12 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Steelville, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation House-wife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name George Hackworth 9

18. Birthplace Dont Know  
(City, town, or county) (State or foreign country)

14. Maiden name Sally Ray

15. Birthplace Steelville, Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Nelson Bell

(b) Address Hattie, Missouri

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Olive

18. (a) Signature of funeral director No Funeral Director

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 12  
year 40 hour 4:00 minute 0. M.

21. I hereby certify that I attended the deceased from 2-8  
1940 to 2-12- 1940

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia 1WK.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Senility  
(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? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature W. J. Hallahan (M. D. or other) 1

Address Willow Springs Date signed 2-13-40

**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.....

**RECEIVED**  
working under my personal supervision.

District Health Officer No. 5,

District File Number 340 298

Date Filed 3/240

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **8427**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
Registration District No. **1077**

Primary Registration District No. **6142**

Registrar's No. ....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH:**  
 (a) County **Texas**  
 (b) City or town **Dale T.P.**  
 (c) Name of hospital or institution:  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution..... (Specify whether  
 In this community..... (Specify whether  
 years, months or days)

**3. (a) PRINT FULL NAME** **Mary Bell**  
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **7** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **wed**  
 6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year  
 7. Birth date of deceased..... (Month) (Day) (Year)

**8. AGE:** Years **89** Months **3** Days **12** If less than one day hr. min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

**MOTHER FATHER**  
 12. Name.....  
 13. Birthplace..... (City, town, or county) (State or foreign country)  
 14. Maiden name.....  
 15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)  
 (c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) (Date received local registrar) (b) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **Texas** (b) County **Texas**  
 (c) City or town **Rural Dale T.P.** (If outside city or town limits write "RURAL")  
 (d) Street No. (If rural, give location)  
 (e) If foreign born, how long in U. S. A.?..... years.

**DECEASED CERTIFICATION**  
 20. DATE OF DEATH Month **2** day **12** year **1940** hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on..... and that death occurred on the date and hour stated above.  
 Immediate cause of death.....

Due to.....  
 Due to.....  
 Other conditions..... (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?..... (City or town) (County) (State)  
 (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 **P. J. Callahan** (M. D. or other).....  
 Address **Willow Springs** Date signed.....

SUPPLEMENTAL

Duration.....  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

