

Registration District No. \_\_\_\_\_ Primary Registration District No. **294**

1. PLACE OF DEATH:  
 (a) County **Franklin**  
 (b) City or town **Rural Central**  
 (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 \_\_\_\_\_  
 In this community \_\_\_\_\_  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **mo** (b) County **Franklin**  
 (c) City or town **Rural**  
 (d) Street No. \_\_\_\_\_  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

3. (a) PRINT FULL NAME **CLARENCE J. BELL**  
 (b) If veteran, name war \_\_\_\_\_  
 (c) Social Security No. **(498-05-1605)**

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **June** day **28**  
 year **1940** hour **11** minute **10** PM.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_  
 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

4. Sex **Male**  
 5. Color or race **White**  
 6. (a) Single, widowed, married, divorced **Married**  
 7. Name of husband or wife **Naomi Bell**  
 8. (c) Age of husband or wife if alive **33** years  
 7. Birth date of deceased \_\_\_\_\_

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

8. AGE:	Years	Months	Days	If less than one day
	<b>37</b>			

Immediate cause of death **Accidental fracture skull neck and right arm**  
 Due to **Collision of motorcycle and automobile at intersection of Hwy 15 & 30**  
 Other conditions \_\_\_\_\_  
 (include pregnancy within 3 months of death)

9. Birthplace **Kentucky**  
 10. Usual occupation **Bucklayer**  
 11. Industry or business **S**  
 12. Name \_\_\_\_\_  
 13. Birthplace \_\_\_\_\_  
 14. Maiden name \_\_\_\_\_  
 15. Birthplace \_\_\_\_\_

Major findings: \_\_\_\_\_  
 Of operations **710 m to**  
 Of autopsy **none**  
 Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature **Coroner**  
 (b) Address \_\_\_\_\_  
 17. (a) **Removal** (b) Date thereof **July 2 1940**  
 (c) Place: burial or cremation **Myrtle Hill**  
 18. (a) Signature of funeral director **W. P. Stoffer**  
 (b) Address **St. Clair, Mo.**  
 19. (a) **July 9, 1940** (b) **W. P. Duckworth**  
 (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) **Accident**  
 (b) Date of occurrence **June 28**  
 (c) Where did injury occur? **Highway 30 & 15 mo**  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**Public Highway at St. Clair mo**  
 While at work? **No** Means of injury **Accident**  
 23. Signature **W. P. Stoffer** (M.D. or P.D.)  
 Address **Sullivan Mo** Date signed **6/29/40**

WHITE 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.

I-X10311

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**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.....

Licensed Embalmer No. *3601*

P. O. Address *St. Clair, 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.**