

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31697**

OCT 12 1940

Registration District No. **163**

Primary Registration District No. **5228**

Registrar's No. **47**

1. PLACE OF DEATH:

(a) County **Cedar**
(b) City or town **Rural - Box 2**
(c) Name of hospital or institution: **None**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2**
(Specify whether years, months or days) **None.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Cedar**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **RED-H 2**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME **LILLIE LEE BELWOOD**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **J. S. Bellwood** 6. (c) Age of husband or wife if alive **74** years
7. Birth date of deceased **Feb 5 1869**
(Month) (Day) (Year)

8. AGE: Years **71** Months **7** Days **15** If less than one day hr. min.

9. Birthplace **Ray Co Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER { 12. Name **James A. Patter**
13. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)
14. Maiden name **Hennetta J. Owen**
15. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)

16. (a) Informant **J. S. Bellwood**

(b) Address **RED-H 2**

17. (a) **Burial** (b) Date thereof **Sept 22 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Clintonville**

18. (a) Signature of funeral director **Robert K. Kunkin**

(b) Address **El Dorado Spgs**

19. (a) **9-21-40** (b) **W. Dawson**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **20**
year **1940** hour **5** minute **50** P.M.

21. I hereby certify that I attended the deceased from **Sept 16**, 19**40**, to **Sept 20**, 19**40**;
that I last saw him alive on **19**, 19**40**;
and that death occurred on the date and hour stated above.

Immediate cause of death: **Chronic Interstitial Nephritis**
Duration _____

Due to _____

Due to **51**

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? **154**

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **W. P. Ray** (M. D. or other) **1**

Address **El Dorado Spgs** Date signed **9-21**

RECEIVED

District Health Officer No. 7,

District File Number 10-40-1404

Date Filed 10-8-40

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

George W. Mofus

Licensed Embalmer No. 2752

P. O. Address El Dorado, Ark.

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.