

7-39)  
K23159

STANDARD CERTIFICATE OF DEATH

State File No. 39422

DEC 17 1946

Registration District No. 157 Primary Registration District No. 5861 Registrar's No.

1. PLACE OF DEATH:

(a) County Ozark

(b) City or town Rural - Richland  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Runs Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 weeks  
(Specify whether)

In this community 28 years  
years, months or days

3. (a) PRINT FULL NAME Cecil Bell

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Hazel Bell

6. (c) Age of husband or wife if alive 27 years

7. Birth date of deceased October 23 1912  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>28</u>		<u>26</u>	hr. _____ min.

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

10. Usual occupation farmer

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

12. Name C. C. Bell

13. Birthplace Ozark Co. Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Vina Howell

15. Birthplace Ozark Co. Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Hazel Bell

(b) Address Trail, Mo

17. (a) Burial (b) Date thereof 11-20-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eaton Cemetery

18. (a) Signature of funeral director D. B. M. Chase

(b) Address Parisville, Mo

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ozark

(c) City or town Rural -  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 19  
year 1946 hour 7 minute 0 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 1946, to Nov 19, 1946, that I last saw him alive on Nov 18, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death Septemia

Due to abscess - appendix

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

Other conditions 121  
(Include pregnancy within 3 months of death)

Major findings: abscess appendix

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature J. P. Wainwright (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

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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.....

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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 39422

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 650

Primary Registration District No. 5861

Registrar's No. ....

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

1. PLACE OF DEATH:

(a) County Warren  
(b) City or town Richland Twp.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Reyno Hosp Mountain Grove Mo  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 weeks  
In this community Cecil Bell  
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 Cecil Bell

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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 28 Months - Days 26 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) 3-15-1944 (b) O. S. Claphook  
(Date received local registrar) (Registrar's signature)

DECEASED CERTIFICATION

20. DATE OF DEATH. Month Nov day 19  
year 1940 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from .....  
....., 19....., to ..... 19.....;  
that I last saw h..... alive on ..... 19.....;  
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 L. G. Vannoy (M. D. or other).....

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL COPY

S-39422 1940