

3. No. 2
4-13-40
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 5759
Registrar's No. 531

Registration District No. 397

Primary Registration District No. 1002

48
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8
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: 5622 E 34th
(d) Length of stay: In hospital or institution _____
In this community _____ years, months or days

3. (a) PRINT FULL NAME Richard E. Bell
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex Male
5. Color race Col
6. (a) Single, widowed, married divorced Baby
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if _____ live _____ years
7. Birth date of deceased Nov. 24 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 6 hr. min.

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

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER
12. Name Deland Bell
13. Birthplace Eufaula Okla.
14. Maiden name Beatrice Johnson
15. Birthplace Miami Mo.

16. (a) Informant Beatrice Bell
(b) Address 5622 E. 34th

17. (a) Burial (b) Date thereof 2 3 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cem.
18. (a) Signature of funeral director Adkins Bros.
(b) Address 2000 E. 12th

19. (a) 2/6/41 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(d) Street No. 5622 E 34th
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. day 1
year 1941 hour 4 minute 15 P. M.

21. I hereby certify that I attended the deceased from 1/19/41
to 2/1/41
that I last saw him alive on 2/1/41
and that death occurred on the date and hour stated above.

Immediate cause of death broncho pneumonia
Duration 5d.

Due to 107a

Due to _____

Other conditions (no) 107
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: no
Of operations _____
Of autopsy _____
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) no
(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? _____

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

23. Signature M. M. Brown (M. D. or other)
Address 2131 E. 24 Date signed 2/3/41

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.