

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FRI. JUL 20 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

21913
State File No. _____
Registrar's No. 23

Registration District No. 036

Primary Registration District No. 5843

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

1. PLACE OF DEATH:
(a) County Oregon
(b) City or town Alton Route 3
(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 39 years
In this community 39 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Oregon
(c) City or town Alton (Rural)
(d) Street No. Alton R. 3
(e) Citizen of foreign country? No
If yes, name country Oregon ex MO

3. (a) PRINT FULL NAME Della Bell
3. (b) If veteran name war --
3. (c) Social Security No. --

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month NOV. day 17
year 41 hour 3 minute 15 A. M.
21. I hereby certify that I attended the deceased from Nov 12 to Nov 12 1941
that I last saw him alive on Nov 16 and that death occurred on the date and hour stated above.

4. Sex Male
5. Color or race
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Violet Bell
6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased Jan. 9 1874
(Month) (Day) (Year)

Immediate cause of death Chronic Myocarditis
D. later Thelasma
Senility
Due to
Other conditions 61
(Include pregnancy within 3 months of death)

8. AGE: Years 67 Months 10 Days 8
If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name Newt Bell

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

14. Maiden name Lottie Hefflin

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

16. (a) Informant Mrs. Della Bell

(b) Address Alton, Mo. Route 3

17. (a) Burial (b) Date thereof 11/17/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hickory Grove

18. (a) Signature of funeral director Leo Carr

(b) Address Thayer, Mo.

19. (a) Thayer, Mo. (b) Sweetwater
(Date received local registrar) (Registrar's signature)

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?
(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 Du Poye Thayer
Address Thayer, Mo. Date signed 11-19-41

1113

(Licensed Embalmer's Statement on Reverse Side)

Cooper

RECEIVED

District Health Officer No. 5,

District File Number 242293

Date Filed 7-17-42

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. 21913
Registrar's No. 23

Registration District No. 636

Primary Registration District No. 5843

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

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town Astoria Rural
(If outside city or town limits, write "RURAL" and name of township)
(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 39 yrs. 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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Della Bell

3. (b) If veteran, name war 11 3. (c) Social Security No. _____

4. Sex m 5. Color White 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 1536

7. Birth date of deceased. Jan 9 1876
(Month) (Day) (Year)

8. AGE: Years 67 Months 10 Days 14 (If less than one day, min.)

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

10. Usual occupation _____

11. Industry of 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ live 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? _____

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

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

