

FILED AUG 24 1942

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

27804

1. PLACE OF DEATH  
 75 County Wagon Registration District No. 636 75  
 0 Township Walden Primary Registration District No. 5843 0  
 0 City Rural (No. \_\_\_\_\_) St. \_\_\_\_\_ (Ward) \_\_\_\_\_

2. FULL NAME Lottie Belle  
 (a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. 0  
 (Usual place of abode) \_\_\_\_\_  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. N. Belle  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 80 6 24  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind 1  
 FATHER 13. NAME Arthur Owen 9  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_  
 MOTHER 15. MAIDEN NAME Arthur Owen 9  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_  
 17. INFORMANT J. N. Sifford  
 (ADDRESS) 1120  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Walden DATE 3/8 14  
 19. UNDERTAKER Hessley  
 (ADDRESS) \_\_\_\_\_  
 20. FILED 3/16 1942 Henry Williams  
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 7 1942  
 22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.  
 I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
 The principal cause of death and related causes of importance were as follows:  
Acid without Medical Aid ✓  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance: \_\_\_\_\_  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) \_\_\_\_\_ M. D. ✓  
 (Address) \_\_\_\_\_

Exact statement of occurrence in plain terms, so that it may be properly classified.

1113

RECEIVED

District Health Officer No. 5,

District File Number 842667.

Date Filed 8-21-42

STANDARD CERTIFICATE OF DEATH

State File No. 27804

Registration District No. 636

Primary Registration District No. 5843

Registrar's No. 12

1. PLACE OF DEATH:

(a) County Oregon  
 (b) City or town 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 \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Lothe Bell

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

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

6. (b) Name of husband or wife Walter Garrison 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased not given  
(Month) (Day) (Year)

8. AGE: Years 80 Months 6 Days 25  
(If less than one day)

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

10. Usual occupation \_\_\_\_\_

11. Industry of business \_\_\_\_\_

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 J. N. Sifford

(b) Address Altam, Mo.

17. (a) Burial (b) Date thereof 3-8-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Moore Family

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) March 16-42 (b) Henry M. Williams  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Oregon  
 (c) City or town Rural  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? No  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day 8 Year 1942 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

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

Immediate cause of death medical aid

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, \_\_\_\_\_ in industrial place, in public place?  
Henry M. Williams  
(Specify type of place)  
 While at work? Not attending to

23. Signature Henry M. Williams (M. D. or other) \_\_\_\_\_  
 Address did not have medical aid

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

MOTHER FATHER

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

