

FILED MAY 15 1943
Registration District No. 1167

Primary Registration District No. 5699

Registrar's No. 6

1. PLACE OF DEATH:

(a) County McDonald
(b) City or town Rocky Comfort, Rural
(If outside city or town limits, write "RURAL" and name of township)
(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..... (Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDonald
(c) City or town Rocky Comfort - Rural
(If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME James B. Belk

3. (b) If veteran name war none 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Ellen Belk 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased July 14 - 1868
(Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days 1 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER { 12. Name Jack Belk
13. Birthplace D.K. 9
(City, town, or county) (State or foreign country)
14. Maiden name D.K.
15. Birthplace A.K. 9
(City, town, or county) (State or foreign country)

16. (a) Informant Ellen Belk

(b) Address Rocky Comfort

17. (a) Burial (b) Date thereof 4-20-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rocky Comfort Mo

18. (a) Signature of funeral director Wheaton Funeral Home

(b) Address Wheaton Mo.

19. (a) 4-25-43 (b) L E Kirk
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15
year 1943 hour 1 minute P.M.

21. I hereby certify that I attended the deceased from Mar. 1, 1934 April 15, 1943
that I last saw him alive on April 14, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic interstitial nephritis
Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death) 13/a

Major findings: 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).....
(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 L. E. Kirk (M. D. or other).....

Address Wheaton Mo. Date signed 4/14/43

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

60
00

RECEIVED

District Health Officer No. 6,

District File Number 543-603

Date Filed MAY 13 1943

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 W. Bennett

Licensed Embalmer No. 4213

P. O. Address Cassville, Mo

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. 14793
Registrar's No. 6

Registration District No. (1167)

Primary Registration District No. (5699)

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

1. PLACE OF DEATH:

(a) County Mc Donald
(b) City or town Rural (Rich Wood Sup)
(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 (Specify whether _____)

3. (a) PRINT FULL NAME

James B. Belk

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 _____ years

7. Birth date of deceased July 16 (Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days 1 (If less than one day _____ min)

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

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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

S-14793