

FILED APR 16 1943

Registration District No. **236**

Primary Registration District No. **6186**

Registrar's No. **101**

1. PLACE OF DEATH:

(a) County **Shannon**
(b) City or town **Summersville Mo.**
(c) Name of hospital or institution:
Spring Valley Home No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **18 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Ethel L. Bellew

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

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

6. (b) Name of husband or wife **Ed. Bellew** 6. (c) Age of husband or wife if alive **47** years

7. Birth date of deceased **July 1 1901** (Month) (Day) (Year)

8. AGE: Years **42** Months **7** Days **24** If less than one day hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business

12. Name **Rige Jones**

13. Birthplace **Not known?** (City, town, or county) (State or foreign country)

14. Maiden name **Gerda Davis**

15. Birthplace **Not known?** (City, town, or county) (State or foreign country)

16. (a) Informant **Ed. Bellew**

(b) Address **Summersville Mo.**

17. (a) **Burial** (b) Date thereof **Feb 27 1943** (Month) (Day) (Year)

(c) Place: burial or cremation **Summersville Cem.**

18. (a) Signature of funeral director **John F. Amear**

(b) Address **1215 New Mo.**

19. (a) **3-16-43** (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **25th** year **1943** hour **8** minute **P.M.**

21. I hereby certify that I attended the deceased from **19** to **19**;

that I last saw **her** alive on **Feb 16**, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis** Duration **4 hrs.**

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) **830**

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) (c) Means of injury

23. Signature **Dr. J. M. Reed** (M. D.)

Address Date signed **3-17-43**

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

RECEIVED

District Health Officer No. 6,

District File Number

Date Filed

44825-4

7-14-42

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

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15656

Registration District No. 336

Primary Registration District No. 6136

Registrar's No.

1. PLACE OF DEATH:

- (a) County Shannon
(b) City or town Summersville
(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 18 yrs
years, months or days

3. (a) PRINT
FULL NAME Ethel L. Belau

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

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

8. AGE: Years 42 Months 7 Days 2 If less than one day
_____ min.

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

10. Usual occupation _____

11. Industry or 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 _____
(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) Frank Hyde MD
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20
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 _____

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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

S-15656