

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18063 ✓

State File No. _____

FILED MAY 18 1943

Registration District No. 146

Primary Registration District No. 3026

Registrar's No. 120

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Independence
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
139 South Oxford
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 45 years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Independence
(If outside city or town limits, write "RURAL")
(d) Street No. 139 South Oxford
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

3. (a) PRINT FULL NAME Anna Mary Bellman

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

4. Sex Female 5. Color or race white
6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife Volney Bellman
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 5 7-1861
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 11 14 hr. _____ min.

9. Birthplace Ky - 1
(City, town, or county) (State or foreign country)

10. Usual occupation at Home

11. Industry or business _____

12. Name William Miller

13. Birthplace Ky - 1
(City, town, or county) (State or foreign country)

14. Maiden name Whegan Williams

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

16. (a) Informant Miss Nettie Bellman

(b) Address 139 South Oxford

17. (a) Removal (b) Date thereof 4-22-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Very Indiana

18. (a) Signature of funeral director W. E. Foster

(b) Address A.P. no

19. (a) 4-23-1943 (b) James [unclear]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 21st
year 1943 hour 4 minute no M.
21. I hereby certify that I attended the deceased from no
1942, to April - 20, 1943
that I last saw her alive on April - 20, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration _____

Due to Senility

Due to _____

Other conditions _____
(include pregnancy within 3 months of death)

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? _____
(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 Fred W. Kirk (M. D. or other) _____

Address 16225 Indep Rd P.C. Date signed 4-22-43

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

DEC 28 1948

Clinton B. By
2 pm

10235-1
10235-1

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 Theron R. Redman

Licensed Embalmer No. 2737

P. O. Address H. C. 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. mc
Registrar's No. 120

Registration District No. 146

Primary Registration District No. 2026

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Independence
(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 45 yrs
years, months or days

3. (a) PRINT FULL NAME Anna Mary Peelman

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 _____

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

7. Birth date of deceased May (Month) 7 (Day) _____ (Year)

8. AGE: Years 81 Months _____ Days _____ If less than one day _____ min.

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

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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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 April year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Bronchial
sepsis
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)

(b) 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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

107

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

5-18063