

33705

State File No. 3240
 Registrar's No. 3240

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED NOV 1 1943
 Registration District No. 13439

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1610 E 10th St
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. One week (Specify whether years, months or days)

3. (a) PRINT FULL NAME CORA I. BELL

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

4. Sex F 5. Color or race Negro 6. (a) Single, widowed, married, divorced M
 6. (b) Name of husband or wife Fred Bell 6. (c) Age of husband or wife 63 years
 7. Birth date of deceased Aug 15 1881
 (Month) (Day) (Year)

8. AGE: Years 62 Months 1 Days 21 If less than one day hr min.

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

10. Usual occupation Housewife

11. Industry or business Self

12. Name John F. Henderson

13. Birthplace Saline Co Mo (City, town, or county) (State or foreign country)

14. Maiden name Maria E. Neft

15. Birthplace Saline Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant Fred D. Bell

(b) Address Marshall Mo

17. (a) Marshall Mo (b) Date thereof Oct 10 1943
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marshall Mo

18. (a) Signature of funeral director F. F. Ferguson

(b) Address Saline Co Mo

19. (a) 10-6-43 (b) J. E. Brown
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline Co
 (c) City or town Marshall
 (If outside city or town limits, write "RURAL")
 (d) Street No. 778 S Jefferson
 (If not, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 6
 year 1943 hour 11 minute 2 AM

21. I hereby certify that I attended the deceased from 10-3 to 10-6 1943
 that I last saw her alive on 11-6 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy

Due to Hypertension

Due to arteriosclerosis

Other conditions none
 (include pregnancy within 3 months of death)

Major findings: none

Of operations none

Of autopsy none

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) (e) Means of injury ---

23. Signature B. C. Ferguson (M. D. or other) ---

Address 1830 2nd St Date 10/6/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

F. L. Ferguson

Licensed Embalmer No. *2172*

P. O. Address.....

Sadalia

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.