

FILED OCT 5 1944

Registration District No. 1944

Primary Registration District No. 3018

State File No. 64

Registrar's No. 64

1. PLACE OF DEATH:

(a) County Dent
(b) City or town Salem
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
X
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution X (Specify whether
In this community 3 months years, months or days)

3. (a) PRINT FULL NAME Dixie Lee Belmont

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

4. Sex female 5. Color or race W 6. (a) Single, widowed, married, 0 divorced child
6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years
7. Birth date of deceased Oct 10 1943
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
- LL 9 hr. min.

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

10. Usual occupation child

11. Industry or business X

12. Name John Belmont
13. Birthplace Kansas City Kans (City, town, or county) (State or foreign country)
14. Maiden name Helen Russell
15. Birthplace Kansas City Mo (City, town, or county) (State or foreign country)

16. (a) Informant John Belmont
(b) Address Salem Mo

17. (a) burial (Burial, cremation, or removal) (b) Date thereof SEPT 23-44
(Month) (Day) (Year)

(c) Place: burial or cremation Cedar Grove Cem

18. (a) Signature of funeral director Charles J. Jones
(b) Address Salem Mo

19. (a) 9-22-44 (Date received local registrar) (b) Joe D. McLeod (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent 33
(c) City or town alem
(If outside city or town limits, write "RURAL")
(d) Street No. X (If rural, give location)
(e) Citizen of foreign country? X (Yes or No)
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 19
year 1944 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from 9/19/44, 1944, to 9/19/44, 1944
that I last saw her alive on 9/19/44
and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia Duration
Staphylococcus

Due to

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 Joe D. McLeod (M. D. or other) Joe D. McLeod
Address Salem Mo Date signed 9/22/44

RECEIVED

District Health Officer No. 5,

District File Number

Date Filed

104-4-491

10-4-48

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

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.