

Registration District No. 6

Primary Registration District No. 5261

1. PLACE OF DEATH:  
(a) County Christian Co  
(b) City or town Harrisonville Route 1  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution about 17 Months  
In this community about 17 Months  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Christian  
(c) City or town Harrisonville MO  
(If outside city or town limits, write "RURAL")  
(d) Street No. Star Route (If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country:

3. (a) PRINT FULL NAME Belle Cora Grabeel  
3. (b) If veteran, name war: -  
3. (c) Social Security No. -

20. DATE OF DEATH: Month Oct day 8  
year 1944 hour 10 minute 2 A.M.

4. Sex F 5. Color or race W  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife: - 6. (c) Age of husband or wife if alive - years  
7. Birth date of deceased: December 14 1861  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 1943 to Oct 8 1944  
that I last saw her alive on June, 1944  
and that death occurred on the date and hour stated above.  
Immediate cause of death: Cerebral Hemorrhage Duration 2 weeks

8. AGE: Years 82 Months 9 Days 24  
If less than one day: hr. min.

Due to: Vascular Hypertension  
Due to: "

9. Birthplace: Quincy Ill  
(City, town, or county) (State or foreign country)  
10. Usual occupation: None

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

11. Industry or business: Thames Medicine  
12. Name: Thames Medicine  
13. Birthplace: Ill  
(City, town, or county) (State or foreign country)  
14. Maiden name: Matilda Best  
15. Birthplace: Ill  
(City, town, or county) (State or foreign country)

Major findings: 830  
Of operations: -  
Of autopsy: -  
PHYSICIAN: -  
Underline the cause to which death should be charged statistically.

16. (a) Informant: Nathan Grabeel  
(b) Address: Springfield Mo  
17. (a) Burial (b) Date thereof: Oct 10 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation: Liberty  
18. (a) Signature of funeral director: W. K. Thompson  
(b) Address: Springfield Mo  
19. (a) 10-9-1944 (b) Mrs. S. M. Johnson  
(Date received local registrar) (Registrar's signature)

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) 2  
Means of injury: no known  
23. Signature: W. K. Nelson (M. D. or other) 24460  
Address: Springfield Mo Date signed: 10-8-44

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

---

---

**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.**