

No. 2
4-17-40
-17-39
X23159

FILED JAN 15 1945
Registration District No. 169

Primary Registration District No. 5621

Registrar's No.

1. PLACE OF DEATH: **KNOX**
 (a) County **KNOX**
 (b) City or town **RURAL - LYON TWP**
 (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 **1**
 In this community **62 years**
 years, months or days (Specify whether)

3. (a) PRINT FULL NAME **IVA MAY BELL**
 3. (b) If veteran, name war.....
 3. (c) Social Security No. **NONE**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **WIDOWED**
 6. (b) Name of husband or wife **JOHN BELL** 6. (c) Age of husband or wife if alive **21** years
 7. Birth date of deceased **FEBRUARY 21 1882**
 (Month) (Day) (Year)

8. AGE: Years **62** Months **10** Days **2** If less than one day
 hr. min.

9. Birthplace **KNOX COUNTY MISSOURI**
 (City, town, or county) (State or foreign country)

10. Usual occupation
 11. Industry or business

12. Name **WILLIAM WILLIAMS**
 13. Birthplace **UNKNOWN**
 (City, town, or county) (State or foreign country)
 14. Maiden name **MARY UNKNOWN**
 15. Birthplace **UNKNOWN**
 (City, town, or county) (State or foreign country)

16. (a) Informant **AMMETT BELL**
 (b) Address **HURDLAND MO. REP.**

17. (a) **BURIAL** (b) Date thereof **12-24-1944**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **BAKER CEMETERY**

18. (a) Signature of funeral director **Edw. J. Breakenfeld**
 (b) Address **Hurdland Mo.**

19. (a) **1-3-45** (b) **Nell Northcutt**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MISSOURI** (b) County **KNOX**
 (c) City or town **RURAL LYON**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **6 MILES NORTH OF HURDLAND MO**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DECEMBER** day **23rd**
 year **1944** hour **1** minute **20 A. M.**

21. I hereby certify that I attended the deceased from **Dec 22**, 1944, to **Dec 23**, 1944;
 that I last saw h.e. alive on **Dec 23**, 1944;
 and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Hemorrhage Duration **2 days**

Due to

Due to

Other conditions
 (Include pregnancy within 3 months of death) **83!**

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 **Edw. J. Breakenfeld** (M. D. or other) **D.D.**
 Address **Edwards Mo** Date signed **12/23/44**

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

200

1142

RECEIVED

District Health Officer No. 10

District File Number 1-45-189

Date Filed JAN 12 1945

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 Geo. B. Bailey

Licensed Embalmer No. 3755

P. O. Address Hurdland 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.

Registration District No. 169

Primary Registration District No. 5621

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lincoln

(b) City or town Primal Lyon sup
(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 _____
years, months or days

3. (a) PRINT FULL NAME Iva May Bell

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

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

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

7. Birth date of deceased Feb 27 1900
(Month) (Day) (Year)

8. AGE: Years 62 Months 10 Days _____ If less than one day _____ min.

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

10. Usual occupation Shoekeeper

MOTHER FATHER

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) _____
(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 Nov 1944 year _____ hour _____ minute _____ M.

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

Duration

Due to _____

Due to _____

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

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____
Date signed _____

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

SUPPLEMENTARY

41420