

FILED MAY 10 1945

Registration District No. **77**

Primary Registration District No. **3008**

Registrar's No. **123**

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

1. PLACE OF DEATH:  
(a) County Callaway  
(b) City or town Fulton  
(c) Name of hospital or institution: State Hospital No. 12  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 yr 6 m 22 d  
In this community 1 yr 6 m 22 d  
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Josephine Bell  
3. (b) If veteran name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race Negro  
6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July 12 1900  
(Month) (Day) (Year)

8. AGE: Years 44 Months 5 Days 28 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Moline Mo  
(City, town, or county) (State or foreign country)  
10. Usual occupation None

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name Joseph Bell  
13. Birthplace Santa Fe Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Markey  
15. Birthplace Santa Fe Missouri  
(City, town, or county) (State or foreign country)  
16. (a) Informant Record  
(b) Address \_\_\_\_\_

17. (a) Removal (b) Date thereof 4-10-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Elmwood Cemetery  
18. (a) Signature of funeral director Elmer Owen  
(b) Address 1019 Veterans Mexico Mo  
19. (a) 4-10-1945 (b) Joce M. ...  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Cudrains  
(c) City or town Medico 14  
(If outside city or town limits, write "RURAL")  
(d) Street No. 520 E. Gumbler  
(If rural, give location)  
(e) Citizen of foreign country? No Yes or No  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 10  
year 1945 hour 12-40 minute 0 M.  
21. I hereby certify that I attended the deceased from 1-30-1945 to 4-10-1945  
that I last saw her alive on 4-10-1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis  
Due to Acute Gastro Enteritis  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations Pne  
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? \_\_\_\_\_  
(Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature Joce M. ... (M. D. or other) MS  
Address Fulton Mo Date signed 4/10/45

RECEIVED

District Health Officer No. 9,

District File Number \_\_\_\_\_

Date Filed 5-9-45

MAY 10 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: J. P. Alford

Licensed Embalmer No. 42-45

P. O. Address Sedalia 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.**