

FILED DEC 12 1945

5135

Registrar's No. 351

Registration District No. .... Primary Registration District No. ....

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Fiske - Rural Post Hill  
(If outside city or town limits, write "RURAL" and name of township)

(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 2 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Butler

(c) City or town Fiske - Rural  
(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 .....

3. (a) PRINT FULL NAME Linda Fay Bell

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 27 year 1945 hour ..... minute ..... M.

4. Sex female 5. Color or race White 6. (a) Single, widowed, married, divorced, single

6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive 25 years (Month) (Day) (Year)

7. Birth date of deceased Nov 25 1945  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 25 1945 to Nov 27 1945  
that I last saw him alive on Nov 27 and that death occurred on the date and hour stated above.

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

Immediate cause of death: Strangulated umbilical cord during birth

Due to substitution of nugs during birth

Due to likely caused a pneumonia

Other conditions: not known  
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

10. Usual occupation .....

Major findings: Of operations none

Of autopsy none

11. Industry or business .....

12. Name C. G. Bell

13. Birthplace Randolph Co Ark  
(City, town, or county) (State or foreign country)

14. Maiden name Wm Chestnut

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

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? ..... Means of injury .....

23. Signature J. C. Bell (M. D. or other) MD  
Address Fiske, Mo Date signed 12/27/45

16. (a) Informant C. G. Bell

(b) Address Fiske, Mo

17. (a) Burial (b) Date thereof 11-28-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shain Memorial Park

18. (a) Signature of funeral director M. S. Shain

(b) Address Fiske, Mo

19. (a) 12-6-45 (b) D. H. Nemerec  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 1245-3395

Date Filed 12/11/45

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**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.**