

U.S. No. 2
OM-8-43
Rev. 5-17-39
I X37823

DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUREAU OF THE CENSUS
U.S. GOVERNMENT PRINTING OFFICE: 1964 O 277-775
FILED MAR 9 1946 STANDARD CERTIFICATE OF DEATH

State File No. 4775
Registrar's No. 79

Registration District No. 47 Primary Registration District No. 3008

1. PLACE OF DEATH:
(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hosp. # 1 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Jan 11-19-1943
(Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. Came here from Jackson Co. Mo. 2
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Alice Bell Bell
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. day 9
year 1946 hour 11 minute 15 A.M.
21. I hereby certify that I attended the deceased from
11-19, 1943, to 2-9, 1946;
that I last saw her alive on 2-5, 1946;
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race col. 6. (a) Single, widowed, married, divorced wid. 7
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased not known
(Month) (Day) (Year)

Immediate cause of death
Chronic myocarditis
Due to Generalized arterio sclerosis
Due to _____
Other conditions Blood syphilis
(Include pregnancy within 3 months of death)
Major findings:
Of operations 309
Of autopsy _____

8. AGE: Years Months Days If less than one day
about 50 hr. min.

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

10. Usual occupation none

11. Industry or business _____

12. Name Geo. Bell

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

14. Maiden name Donna

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

16. (a) Informant Donna
(b) Address _____

17. (a) Removal (b) Date thereof 2 14 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia Mo

18. (a) Signature of funeral director J. B. Roberts
(b) Address Columbia Mo

19. (a) 2-14-1946 (b) Joan Moser
(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) (e) Means of injury _____
Signature J. B. Stokes (M. D. or other) M.D.
Address Fulton Date signed 2-12-46

(Licensed Embalmer's Statement on Reverse Side)

4
1
2
3797
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 28-46

MAR 19 1946

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.