

U.S. No. 2  
FORM-5-43  
REV. 5-17-39  
X 36671

**FILED NOV 23 1946**  
Registration District No. **46**

Primary Registration District No. **5151**

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

1. PLACE OF DEATH: **Caldwell**

(a) County **Caldwell**

(b) City or town **Kidder Twp Rural**  
(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 years, months or days) **65 yrs.**

In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED: **Caldwell**

(a) State **Mo** (b) County **Caldwell**

(c) City or town **Kidder Twp-Rural**  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No) \_\_\_\_\_  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Jerry M. Bell**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **12** year **1946** hour **8** minute **0** M.

21. I hereby certify that I attended the deceased from **Oct 12** 1946 to **Nov 12** 1946 and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **white**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Belle Bell** 6. (c) Age of husband or wife if alive **91** years

7. Birth date of deceased **Aug 15 1860**  
(Month) (Day) (Year)

Immediate cause of death **Acute Epistaxis and Abrasion in spine**

Due to **chronic Colitis**

Due to \_\_\_\_\_

8. AGE: Years **86** Months **2** Days **27** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Other conditions **Could not take aspirin for weak**

(Include pregnancy within 3 months of death)

9. Birthplace **Wayne Co. Ky.**  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_

Of autopsy **120A**

10. Usual occupation **Farming**

11. Industry or business **Stock Raising**

12. Name **Silas Bell**

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

14. Maiden name **Anna Mott**

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

16. (a) Informant **Mrs Matta Humphrey**

(b) Address **Kidder Mo**

17. (a) **Burial** (b) Date thereof **Nov 14 1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Graceland Cem. Cameron Mo.**

18. (a) Signature of funeral director **Bramm Funeral Home**

(b) Address **Hamilton Mo.**

19. (a) **Nov 14/46** (b) **Glady's Jones**  
(Date received by 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)

23. Signature **Lee E. Oaks** (M. D. or other) **0**

Address **Hamilton Mo** Date signed **11/13/46**

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

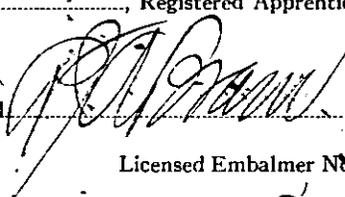
Underline the cause to which death should be charged statistically.

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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.

3057

P. O. Address

Summitton, 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.