

**FILED JUL 10 1947**

Registration District No. 141

Primary Registration District No. 3025

Registrar's No. 4

**1. PLACE OF DEATH:**

(a) County Howell  
 (b) City or town West Plains  
(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** Mary C. Kristine Bell

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

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

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

7. Birth date of deceased.....  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
 hr. min.  
4 21

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

10. Usual occupation Infant

11. Industry or business.....

12. Name Clayton Bell

13. Birthplace Clark Co Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Betty M. Farland

15. Birthplace Union Co Ark  
(City, town, or county) (State or foreign country)

16. (a) Informant Clayton Bell

(b) Address West Plains Mo

17. (a) B (b) Date thereof 4-16-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Lawn

18. (a) Signature of funeral director Robitson's

(b) Address West Plains Mo

19. (a) June 30-47 (b) Beatrice Cook  
(Date received local registrar) (Registrar's signature) 379

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Howell  
 (c) City or town West Plains  
(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 4 day 15  
 year 1947 hour 2 minute 50A.M.

21. I hereby certify that I attended the deceased from 4-14-1947 to 4-15-1947  
 that I last saw her alive on 4-14-1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia

Due to.....

Due to.....

Other conditions U7  
(Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

**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?  
11

While at work?.....  
(Specify type of place) (e) Means of injury

23. Signature E. B. Bohrer (M. D. or other) MD

Address West Plains Mo Date signed 4-19-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

H1

RECEIVED

District Health Officer No. 5,

District Officer

747374

Date Filed

7-8-47

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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.....

*George S. Drago*....., Registered Apprentice No. *431*  
working under my personal supervision.

Signed *H. D. Robertson*.....

Licensed Embalmer No. *3432*.....

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.**