

S. No. 2
1-12-45
5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33997

State File No. _____

FILED NOV 13 1947

Registration District No. 77

Primary Registration District No. 5287

Registrar's No. 173

1. PLACE OF DEATH:

(a) County CLAY
(b) City or town RURAL - R.F.D.# 2 Felton Bluffs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1 MILE WEST OF EXCELSIOR SPRINGS
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community LIFETIME
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County: CLAY 24
(c) City or town RURAL - R.F.D.# 2
(If outside city or town limits, write "RURAL")
(d) Street No. 1 MILE WEST OF EXCELSIOR SPRINGS
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME BELLE V. IOTT

3. (b) If veteran, name war NO 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife CLIFF IOTT 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased DEC. 25 1891
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
55 10 6 _____ hr. _____ min.

9. Birthplace EXCELSIOR SPRINGS MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business AT HOME

12. Name CLABE STOREY

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

14. Maiden name VIRGINIA WYSONG

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

16. (a) Informant Cliff Iott

(b) Address RT. #2, EXCELSIOR SPRINGS, MO.

17. (a) BURIAL (b) Date thereof 11-3-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CROWN HILL

18. (a) Signature of funeral director Blaude Prichard

(b) Address EXCELSIOR SPRINGS, MO

19. (a) 11-2-47 (b) Caroline Hutelings
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 31 ST
year 1947 hour 4 minute 00 A.M.

21. I hereby certify that I attended the deceased from 8/28
1947 to 10/21 1947
that I last saw EM alive on 10/21 1947
and that death occurred on the date and hour stated above.

Immediate cause of death CARCINOMA OF THE HEPATIC FLEXURE OF COLON METASTASIS OF LIVER
Duration UNKNOWN

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)
Major findings: OPERATED* CECOSTOMY
Of operations _____
Of autopsy Hist

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) 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 _____

23. Signature Dr. M. E. Bruden (M. D. or other) MD.

Address Excelsior Springs Mo. Date signed 11/1/47

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 11-13-47

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. E. White

Licensed Embalmer No. 4168

P. O. Address Exp. Spgs. 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.