

No. 2
-8-43
5-17-39
X37823

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34081**

FILED OCT 28 1947

Registration District No. **96**

Primary Registration District No. **5350**

Registrar's No. **64**

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

1. PLACE OF DEATH:

(a) County Dallas

(b) City or town Rural - Lincoln
(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 _____ (Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Martha Luella Belknap

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Mar 24 1879
(Month) (Day) (Year)

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

68 6 16 0 hr. 0 min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Jonah Reser

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

14. Maiden name Mary E. Bower

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

16. (a) Informant Mr. John Crabtree

(b) Address Urbana, Mo

17. (a) Burial (b) Date thereof 10/12/1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bowers Chapel - Conn

18. (a) Signature of funeral director Vaughan Reser

(b) Address Urbana, Mo

19. (a) 10/19/47 (b) J. B. Jones
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dallas **30**

(c) City or town Rural
(If outside city or town limits, write "RURAL") **00**

(d) Street No. _____ (If rural, give location) **0**

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 10
year 1947 hour 12:00 minute 17 M.

I hereby certify that I attended the deceased from Sept 15 to Oct 10 1947
that I last saw her alive on Oct 9 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Subarachnoid Hemorrhage **5dy**
diabetes insipidus **3dy**
hypertension

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? _____

23. Signature J. B. Jones (M. D. or other) **10/14/47**

Address Urbana Mo Date signed _____

RECEIVED
DISTRICT HEALTH OFFICE NO. 7
District No. 10-27-47
Date Filed 9-47-48

Handwritten notes and signatures:
10-27-47
9-47-48
District Health Office No. 7
District No. 10-27-47
Date Filed 9-47-48

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.....

Glenn D. Williams....., Registered Apprentice No. *13*
working under my personal supervision.

Signed *Allen W. Vaughan*
Licensed Embalmer No. *4156*
P. O. Address *Urbana, 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.