

UNITED STATES DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29415**

FILED OCT 13 1948

Registration District No. **118**

Primary Registration District No. **#189 5439**

Registrar's No. **6**

1. PLACE OF DEATH:

(a) County **Gasonade**
(b) City or town **Rosebud Rural**
(c) Name of hospital or institution: **Home**
(If outside city or town limits, write "RURAL" and name of township)

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community **15 years** (Specify whether years, months or days)

3: (a) PRINT FULL NAME **RUBY L. BELLOR**
3: (b) If veteran, name war **L**
3: (c) Social Security No. **L**

4. Sex **female**
5. Color or race **white**
6: (a) Single, widowed, married, divorced **married**
6: (b) Name of husband or wife **John J. Bellor**
6: (c) Age of husband or wife if alive **44** years
Birth date of deceased **March 11 1907**
(Month) (Day) (Year)

8. AGE: Years **41** Months **6** Days **19**
If less than one day hr. min.

9. Birthplace **Dayton Kentucky**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER
12. Name **Allie C. Thacker**
13. Birthplace **Hammond Kentucky**
(City, town, or county) (State or foreign country)
14. Maiden name **Myra H. Hedges**
15. Birthplace **Flayford Kentucky**
(City, town, or county) (State or foreign country)

16: (a) Informant **John J. Bellor**
(b) Address **Rosebud Rural Mo**

17: (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **10-3-48**
(Month) (Day) (Year)

(c) Place: burial or cremation **M.E. Rosebud Mo**

18: (a) Signature of funeral director **E. J. Meyer & Son**
(b) Address **General Mo**

19: (a) **Oct 2 1948** (Date received local registrar) (b) **Dorothy Rackman** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Gasonade**
(c) City or town **Rosebud 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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9-30** day
year **1948** hour **9** minute **P** M.

21. I hereby certify that I attended the deceased from **Dec 1945** to **8-20 1948**
that I last saw her alive on **8-20 1948**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Cecum**
Duration **3 yrs**

Due to

Due to

Other conditions **None**
(Include pregnancy within 3 months of death)

Major findings: Of operations **Cc of Cecum**
Of autopsy **none 46E**

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?

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

23. Signature **Alan A. Schubert** (M. D. or other) **MD**
Address **Rosebud Mo** Date signed **10-2-48**

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

Date Filed OCT 12 1948

District File No. 100

District Health Officer No. 9

RECEIVED

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.....

STANLEY E MEYER....., Registered Apprentice No. 209
working under my personal supervision.

Signed Earl C. Heitzig.....

Licensed Embalmer No. 3385

P. O. Address New Haven 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.