

No. 2  
1/47  
17.39

FILED NOV 17 1948

State File No. ....

Registration District No. 340

Primary Registration District No. 30756152

Registrar's No. 64

1. PLACE OF DEATH:

(a) County Stoddard  
(b) City or town Dexter, Mo. Route 1  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 3  
(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 BARBARA ANN BELT

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 Sept 7 1945  
(Month) (Day) (Year)

8. AGE: Years 2 Months 2 Days 2 If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name Aubrey Duane Belt

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

14. Maiden name Marjorie Hulse

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

16. (a) Informant Mrs. Aubrey Belt

(b) Address Malden Mo.

17. (a) Burial (b) Date thereof Nov. 9, 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Malden Cemetery

18. (a) Signature of funeral director Walter Hulse

(b) Address Dexter Mo.

19. (a) 11-10-48 (b) Valma Jenkins  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Dunklin  
(c) City or town Malden Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 7  
year 1948 hour..... minute 3 A.M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....  
that I last saw him..... alive on....., 19.....  
and that death occurred on the date and hour stated above. Duration

Immediate cause of death investigation shows accidental suffocation

Due to.....

Due to.....

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

Major findings: Of operations 182  
Of autopsy 15

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) accidental suffocation

(b) Date of occurrence Nov. 7, 1948

(c) Where did injury occur? Dexter Stoddard Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home of grandparents at Dexter

While at work?..... (Specify type of place)

Means of injury 3

23. Signature W. Hulse (M. D. or other) cor.

Address Dexter, Mo. Date signed 11-7-48

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

RECEIVED

District Health Office No. 2,

District File Number 1148-15-474

Date Filed 11-15-46

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 \_\_\_\_\_

Not embalmed

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed Lynna Steel

Licensed Embalmer No. 2476

P. O. Address Dexter 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.

No. 2B  
3-A  
1 X43880

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Dec  
Registrar's No. 64

Registration District No. 340 Primary Registration District No. 6152

1. PLACE OF DEATH:  
(a) County Stoddard  
(b) City or town Liberty Township R #1  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Barbara Ann Bell  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased Sept 7 (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ (Less than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) H (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 \_\_\_\_\_ year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

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

Other conditions (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? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

39099