

FILED APR 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14143

BIRTH NO. REG. DIST. NO. 290 PRIMARY REG. DIST. NO. 4427 Registrar's No. 39

1. PLACE OF DEATH a. COUNTY Pulaski		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Calloway	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Waynesville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fulton	
d. FULL NAME OF HOSPITAL OR INSTITUTION Waynesville General Hospital		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) Claud b. (Middle) William c. (Last) Bell		4. DATE OF DEATH (Month) (Day) (Year) 4 5 1950	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 4/5/1909
9. AGE (In years last birthday) 41		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Wilbert Bell		13b. MOTHER'S MAIDEN NAME Rena Dill		14. NAME OF HUSBAND OR WIFE Rosella Belle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 499 03 7464		17. INFORMANT'S SIGNATURE OR NAME Mrs. Rosella Bell Fulton, Missouri	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fractured skull ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH approx 2 hours 68234 32	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 785		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) Auto accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway near Dixon Mo		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Nunda 28, Dixon Mo	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? ROR	

22. I hereby certify that I attended the deceased from **4-4**, 19**50**, to **4-4**, 19**50**, that I last saw the deceased alive on **4-4**, 19**50** and that death occurred at **2:50 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE E. E. Fendley, M.D. (Degree or title)		23b. ADDRESS Rolla Mo		23c. DATE SIGNED 4-5-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4/8/50		24c. NAME OF CEMETERY OR CREMATORY Kenner Cemetery	
24d. LOCATION (City, town, or county) (State) Marion County, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE W. C. Birmingham		ADDRESS Kennett Mo	
DATE REC'D BY LOCAL REG. 4-15-50		REGISTRAR'S SIGNATURE Thelma C. Buckthorpe		389	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 4/11/50

Pulaski County Health Officer

File Number _____

Date Filed 4/15/50

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 _____

working under my personal supervision.

Student
Student Embalmer

Student Embalmer No. _____

Signed _____

Licensed Embalmer No. _____

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.