

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23253**

FILED AUG 14 1950

BIRTH NO. _____ REG. DIST. NO. **126** PRIMARY REG. DIST. NO. **2000** Registrar's No. **711**

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

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Howell	
b. CITY OR TOWN Springfield		c. CITY OR TOWN Willow Springs	
c. LENGTH OF STAY (in this place) 12 days		d. STREET ADDRESS (If rural, give location) none	
d. FULL NAME OF HOSPITAL OR INSTITUTION OSZARK OSTEOPATHIC HOSPITAL			

3. NAME OF DECEASED (Type or Print)	a. (First) SARAH	b. (Middle) EMMA	c. (Last) Bell	4. DATE OF DEATH (Month) (Day) (Year) 8-8-50
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 2-13-1875	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months 7 Days 20	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY House keeper	11. BIRTHPLACE (State or foreign country) Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Arthur Bell
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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. No	17. INFORMANT'S SIGNATURE OR NAME Florence Holmes - Wichita Kansas	ADDRESS Wichita Kansas
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Medullary failure		INTERVAL BETWEEN ONSET AND DEATH 2 1/2
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypostatic pneumonia		
	DUE TO (c) Following surgery on left hip		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION 7-29-50	19b. MAJOR FINDINGS OF OPERATION Fracture of neck of left femur	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Willow Springs Howell Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 7-28-50 2 a.m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? fell at home 046

22. I hereby certify that I attended the deceased from **7-28, 1950**, to **8-8, 1950**, that I last saw the deceased alive on **8-8, 1950**, and that death occurred at **11:50 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE Deland & Utter V Co.	(Degree or title)	23b. ADDRESS Springfield, Mo	23c. DATE SIGNED 8/8/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8/10/50	24c. NAME OF CEMETERY OR CREMATORY Willow Springs	24d. LOCATION (City, town, or county) (State) Willow Springs Mo
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 8-10-50 W.E. Handley	25. FUNERAL DIRECTOR'S SIGNATURE Herman H. Schaefer, Inc	ADDRESS Springfield, Mo
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SEP 26 1951

DEC 11 1951

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.....

Student Embalmer No.

working under my personal supervision.

Signed William Greer

Signed
Student Embalmer

Licensed Embalmer No. 4733

P. O. Address Springfield, 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.