

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

32465

State File No.

FILED OCT 16 1950

BIRTH NO.		REG. DIST. NO. <u>374</u>		PRIMARY REG. DIST. NO. <u>6276</u>		Registrar's No. <u>47</u>	
1. PLACE OF DEATH a. COUNTY <u>Worth</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Worth</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Union Township</u>				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Union Township</u> <u>1130</u>			
c. LENGTH OF STAY (In this place) <u>55 years</u>				d. STREET ADDRESS (If rural, give location) <u>Grant City</u> <u>0</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Grant City</u>							
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Robert</u>		b. (Middle) <u>Bell</u>		c. (Last) <u>Bell</u>	
4. DATE OF DEATH		(Month) <u>10</u> (Day) <u>5</u> (Year) <u>1950</u>					
5. SEX <u>male</u> <u>0</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>9 10 1891</u>	9. AGE (In years last birthday) <u>59</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>25</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming for self</u>		11. BIRTHPLACE (State or foreign country) <u>Clearfield, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William Bell</u>		13b. MOTHER'S MAIDEN NAME <u>Rebecca Grindstaff</u>		14. NAME OF HUSBAND OR WIFE <u>Mabel Frances Bell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>William Bell, Jr. Blockton, Iowa</u>			
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) <u>Cerebral Hemorrhage</u> 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. 331X				INTERVAL BETWEEN ONSET AND DEATH <u>Three</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-47</u> , to <u>10-5</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>10-5</u> , 19 <u>50</u> , and that death occurred at <u>11-7</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Frank B. Harrison M.D.</u>				23b. ADDRESS <u>Grant City, Mo.</u>		23c. DATE SIGNED <u>10/11/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10 7 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Grant City Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Grant City, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Oct. 11-1950</u>		REGISTRAR'S SIGNATURE <u>John E. Dawson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Dunfee</u>		ADDRESS <u>Grant City, Missouri</u>	

(Licensed Embalmer's Statement on Reverse Side)

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



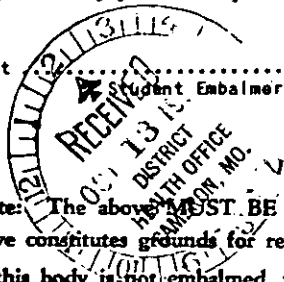
STATEMENT BY LICENSED EMBALMER

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.

Student _____



Signed Arch C. Dunfee

Licensed Embalmer No. 3252

P. O. Address Grant city, 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.