

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21272**
Registrar's No. **605**

35452
FILED JUN 29 1953

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000**

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 Mo. b. COUNTY Webster	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	c. LENGTH OF STAY (in this place) 3 days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshfield, Mo.	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION OSZARK OSTEOPATHIC HOSPITAL		d. STREET ADDRESS (If rural, give location) 1120,	

3. NAME OF DECEASED (Type or Print) a. (First) Clifford	b. (Middle) Leroy	c. (Last) Bell Jr.	4. DATE OF DEATH (Month) (Day) (Year) 6 24 53
5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH June 21-53
9. AGE (in years last birthday) —	IF UNDER 1 YEAR Days 3	IF UNDER 6 MRS. Hours	IF UNDER 1 MIN.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Springfield, Mo.
13a. FATHER'S NAME Clifford Leroy Bell			12. CITIZEN OF WHAT COUNTRY? U.S.A.

13b. MOTHER'S MAIDEN NAME Virginia Mae Hund	14. NAME OF HUSBAND OR WIFE NONE	
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. —	
17. INFORMANT'S SIGNATURE OR NAME Clifford Bell		ADDRESS Marshfield

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity	DUE TO (b) Miscarriage		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	DUE TO (c) Maternal cause is unknown		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death (28 weeks gestation)			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 776 x		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) m.	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 **6-21, 1953**, to **6-24, 1953** that I last saw the deceased alive on **6-24, 1953**, and that death occurred at **4:15 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Eland B. Welch MD	23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 6/24/53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-25-53	24c. NAME OF CEMETERY OR CREMATORY Marshfield
24d. LOCATION (City, town, or county) (State) Marshfield, Mo.	25. FUNERAL DIRECTOR'S SIGNATURE Barber Barto	ADDRESS Marshfield
DATE REC'D BY LOCAL REG. 6-26-53	REGISTRAR'S SIGNATURE Edith Williamson	

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
Student Embalmer

Signed *Not Embalmed.*

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.