

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42409

FILED DEC 18 1956

STATE FILE NUMBER

Registration District No. 276 Primary Registration District No. 5945- Registrar's No. 80

Health, Welfare, Public Service

0000-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

ALL diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

0810

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Bollinger</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural - N. Dillon</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Rural</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ferndale Rest Home</u>		Length of stay in lb <u>2 mo 4 wks</u>	d. STREET ADDRESS (If outside, give location) <input checked="" type="checkbox"/> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>M.</u> Last <u>Bell</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>10</u> Year <u>1956</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 12, 1868</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	11. BIRTHPLACE (City and state or country) <u>Bollinger Co, MO.</u>
13. FATHER'S NAME <u>Thos. Bell</u>		14. MOTHER'S MAIDEN NAME <u>Louise Bollinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT <u>Ferndale Rest Home</u> Address <u>Office - St James, Mo.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>about 6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>7-28-1949</u> to <u>Dec 10, 1956</u> and last saw him alive on <u>11-29-1956</u> Death occurred at <u>7:30 Am</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>C. V. Hammler, M.D.</u> (Degree or title)		22b. ADDRESS <u>St. James, Mo.</u>	22c. DATE SIGNED <u>12-11/56</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Dec. 14-1956</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FARMINGTON CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>FARMINGTON MO</u>
24. FUNERAL DIRECTOR <u>COZEAN Funeral Home - Farmington</u> ADDRESS <u>MO</u>		25. DATE RECD. BY LOCAL REG. <u>12-12-1956</u>	26. REGISTRAR'S SIGNATURE <u>Ruth B. Powell</u>

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

Phelps County Health Officer,

County File Number 579

Date Filed DEC 17 1956

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 me Student Embalmer No.
working under my personal supervision..

Student
Signature of Student Embalmer

Signed Oral E. Lickel

Licensed Embalmer No. 35

P. O. Address St. James

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.