

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

12125
 State File No.

FILED MAY 6 - 1957

BIRTH NO. _____		REG. DIST. NO. <u>38</u>		PRIMARY REG. DIST. NO. <u>5121</u>		Registrar's No. <u>148</u>			
1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) —a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>					
b. CITY (If outside corporate limits, write RURAL and give townships) OR TOWN <u>Rural (Perche Township)</u>		c. LENGTH OF STAY (in this place) <u>15 yrs</u>		c. CITY OR TOWN <u>Harrisburg, Mo.</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>9 miles S. E. Harrisburg, Mo.</u>				e. STREET ADDRESS (If rural, give location) <u>0100 Route 1, Harrisburg, Mo.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u> b. (Middle) <u>Henry</u> c. (Last) <u>M. Bell</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>4</u> <u>28</u> <u>57</u>						
5. SEX <u>0</u> <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Nov. 25, 1883</u>			
9. AGE (In years last birthday) <u>73</u>		10. VISUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Bell</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Franklin County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Harve Bell</u>			13b. MOTHER'S MAIDEN NAME <u>Bertha Smith</u>			14. NAME OF HUSBAND OR WIFE <u>Katherine Bell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Russell Bell, Harrisburg, Mo.</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, athermia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial decompensation</u> ANTECEDENT CAUSES Cardiac asthma Senile debility. II. OTHER SIGNIFICANT CONDITIONS Emaciation and malnutrition				INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>about 5 yrs.</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) <u>4342</u>					
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? _____					
22. I hereby certify that I attended the deceased from <u>Jan 8, 1954</u> , to <u>April 28, 1957</u> , that I last saw the deceased alive on <u>April 14, 1957</u> , and that death occurred at <u>5 A</u> m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Walter E. Barker D.O.</u>				23b. ADDRESS <u>Columbia, Mo.</u>		23c. DATE SIGNED <u>4-29-57</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>4-30-1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery, Columbia, Mo.</u>		24d. LOCATION (City, town, or county) (State) _____			
DATE REC'D BY LOCAL REG. <u>Apr 29, 1957</u>		REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmer</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Funeral Service, Columbia, Mo.</u>					

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

31-0

MAY 14 1967

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.....
Signature of Student Embalmer

Signed *Lyman H. Spangle*

Licensed Embalmer No. *4013*

P. O. Address *Columbia*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.