

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9-000205
STATE FILE NUMBER

9 1959 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 56

1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Francois	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia		c. CITY OR TOWN Bismark	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR KNOWN LOCATION Ellis Fischel State		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anvil Middle Franklin Last Kell		4. DATE OF DEATH Month February Day 3 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH September 27 1886
9. AGE (In years last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Work	11. BIRTHPLACE (City and state or country) Texas Co. Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Andrew Kell	
14. MOTHER'S MAIDEN NAME Mary Freeze		15. NAME OF HUSBAND OR WIFE Div.	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		17. SOCIAL SECURITY NO. Unknown	
18. INFORMANT Hospital Records - Highway 40		19. INTERVAL BETWEEN ONSET AND DEATH 3 mos	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Bladder with bilateral ureteral obstruction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None			19. WAS AUTOPSY PERFORMED? 1 YES <input checked="" type="checkbox"/> NO <input 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 <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 1-16-59 to 2-3-59 and last saw him alive on 2-3-59 Death occurred at 5:15 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) D. J. Schewe M.D.		22b. ADDRESS State Cancer Hosp.	
22c. DATE SIGNED 2-4-59		23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	
23b. DATE 2-6-1959		23c. NAME OF CEMETERY OR CREMATORY MCNIHARAN	
23d. LOCATION (City, town, or county) (State) NE. OF RAYMONDVILLE MO		24. FUNERAL DIRECTOR L. J. Evans Houston, Mo.	
25. DATE RECD. BY LOCAL REG. Feb 4 1959		26. REGISTRAR'S SIGNATURE Mrs R E Palmer	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

FEB 11 1959

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 *Lewell C. Craig*

Licensed Embalmer No. *4766*

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