

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006746

STATE FILE NUMBER

Registration District No. 301 Primary Registration District No. 4450 Registrar's No. 16

100
-57

1. PLACE OF DEATH a. COUNTY Ripley		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Ripley	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Doniphan		c. CITY OR TOWN BRIAR	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Doniphan Community		d. STREET ADDRESS (If outside, give location) 2 days	
3. NAME OF DECEASED (Type or print) First Middle Last Coleman B. Bell		4. DATE OF DEATH Month Day Year Feb. 23, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1877
9. AGE (In years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	
11. BIRTHPLACE (City and state or country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Elsie Bell		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 Address Elsie Bell - BRIAR, Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Generalized arteriosclerosis DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 48 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331x		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
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 a.m. Month, Day, Year 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 Death occurred at June 1958 to 2/23/59 and last saw him alive on 2/23/1959 1145 p m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Frank Johnson M.D.	
22b. ADDRESS Doniphan Mo		22c. DATE SIGNED 2/27/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 26, 1959	
23c. NAME OF CEMETERY OR CREMATORY Bennett Cemetery		23d. LOCATION (City, town, or county) (State) Ripley County, Missouri	
24. FUNERAL DIRECTOR ADDRESS Edwards Funeral Home Doniphan Mo		25. DATE RECD. BY LOCAL REG. 3-6-59	
26. REGISTRAR'S SIGNATURE Flava Broz			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Gene Harrent*

Licensed Embalmer No. *4809*
P. O. Address *Naylor, 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.