

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012123

STATE FILE NUMBER

FILED MAR 25 1959 Registration District No. 370 Primary Registration District No. 4540 Registrar's No. 10

1. PLACE OF DEATH a. COUNTY WAYNE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY WAYNE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN IN ROUTE TO HOSP.		c. CITY OR TOWN GREENVILLE	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION NEAR BUTLER CO. HME		d. STREET ADDRESS (If outside, give location) ✓	

3. NAME OF DECEASED (Type or print) First Middle Last MARY ANGELINE BELL			4. DATE OF DEATH Month Day Year MAR. 19 1959		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH APR 16, 1880	9. AGE (In years) 78	IF UNDER 1 YEAR Month Day Hours Min. 11 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) LOWNDES, MO.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME RUEUS HEFNER	13b. MOTHER'S MAIDEN NAME MARTHA ANGELINE BARK	14. NAME OF HUSBAND OR WIFE JAMES ELI BELL
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ✓	16. SOCIAL SECURITY NO. ✓	17. INFORMANT FERN SHARP

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia DUE TO (b) Influenza DUE TO (c) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 480X
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	

20d. INJURY OCCURRED WHILE AT ☐ NOT WHILE AT WORK ☐	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION Greenville, Mo	COUNTY Wayne	STATE MO
21. I attended the deceased from 3/18/59 to 3/18 and last saw her alive on 3/19/59 Death occurred at 9:00 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE Sam Taylor MD	(Deceased or title)	22b. ADDRESS Greenville, Mo	22c. DATE SIGNED 3/21/59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 3/22/1959	23c. NAME OF CEMETERY OR CREMATORY LOWNDES CEM.	23d. LOCATION (City, town, or county) (State) LOWNDES MO

24. FUNERAL DIRECTOR GISH FUNERAL HOME	ADDRESS GREENVILLE, MO.	25. DATE RECD. BY LOCAL REG. Mar. 23 1959	26. REGISTRAR'S SIGNATURE Arthur M. Ward
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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

Student _____
Signature of Student Embalmer

Signed Mawin E. Bowles

Licensed Embalmer No. 4426

P. O. Address Frederick, Md.

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.