

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-014005

STATE FILE NUMBER

FILED MAY 4 1959 Registration District No. 179 Primary Registration District No. 5667 Registrar's No. 43

1. PLACE OF DEATH a. COUNTY <b>LINCOLN</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>PIKE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>TROY MO</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>EOLIA</b> <b>0820</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>LINCOLN CO. MEM. HOSP.</b>		Length of stay in lb <b>28 DAYS</b>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES HENRY BELL</b>			4. DATE OF DEATH Month Day Year <b>FEB 12 1959</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 12 1876</b>
9. AGE (In years, months, days) <b>82.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	11. BIRTHPLACE (City and state or country) <b>LINCOLN CO. MO.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>BENJAMIN W. BELL</b>	
13b. MOTHER'S MAIDEN NAME <b>LUCY SPRINGSTON</b>		14. NAME OF HUSBAND OR WIFE <b>NANNIE EASTON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or up to you) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. ARTHUR BELL</b>		Address <b>EOLIA, MO.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SINO-AURICULAR HEART BLOCK</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 MINUTES</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>			<b>UNKNOWN</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)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <b>JAN. 15, 1959</b> to <b>FEB 12, 1959</b> and last saw him alive on <b>FEB 12, 1959</b> Death occurred at <b>FEB 12, 1959 1:55 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Paul D. Berry M.D.</b>		22b. ADDRESS <b>Troy, Mo.</b>	22c. DATE SIGNED <b>2/16/59</b>
23a. BURIAL, CREMATION, or other disposition (Specify) <b>BURIAL</b>	23b. DATE <b>FEB 14 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREENWOOD</b>	23d. LOCATION (City, town, or county) (State) <b>CLARKSVILLE MO</b>
24. FUNERAL DIRECTOR <b>GEO. M. COLLIER</b>		ADDRESS <b>LOUISIANA, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>4-27-59</b>
26. REGISTRAR'S SIGNATURE <b>Charlotte Leek</b>			

(Licensed Embalmer's Statement on Reverse Side)

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 *Geo. M. Callier* .....

Licensed Embalmer No. *3839* .....

P. O. Address *Louisiana* .....

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.