

**URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS NOV 30 1959**

**5440** **59-039919**  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

RECEIVED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Jackson</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>49 yrs.</b>	c. CITY OR TOWN <b>Kansas City</b>
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>Riverview Nursing Home</b> <b>540 Highland</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5071 Glenside Drive</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First <b>ERNEST</b> Middle <b>ROBERT</b> Last <b>BELL</b>			<b>4. DATE OF DEATH</b> Month <b>11</b> Day <b>11</b> Year <b>1959</b>		
---	--	--	---	--	--

<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>2-25-78</b>	<b>9. AGE (last birthday)</b> <b>81</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____
------------------------------	---	---	---	--	---	---

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Baker</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Bakeries</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Clinton, Missouri</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>
--	---	---	---

<b>13a. FATHER'S NAME</b> <b>Samuel Bell</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Malissa Wetzel</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Nattie Cook</b>
---	---	--

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) (If yes, give war or dates of service)	<b>16. SOCIAL SECURITY NO.</b> <b>509-07-0861A</b>	<b>17. INFORMANT</b> <b>Mr. John Wessel: 5071 Glenside Dr.</b>
--	---	---

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the mouth (Squamous cell. with metastases)</b>		K. C. STORY MO ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> , but not related to the terminal disease condition given in PART I (a)	<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
--	---

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
--	--	---

<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____
--

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE
---	---	--

**21. I attended the deceased from** 5-4-59 to 11-11-59 and last saw him alive on 11-7-59  
**Death occurred at** 11-11-59 2:55 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <i>Robert F. Goodwin MD</i>	<b>22b. ADDRESS</b> <b>5239 Catalina K.C. 3 Mo</b>	<b>22c. DATE SIGNED</b> <b>11-12-59</b>
--	---	--

<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE</b> <b>11-13-59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Forest Hill Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>Kansas City, Missouri</b>
---	-------------------------------------	--	--

<b>24. FUNERAL DIRECTOR</b> <b>WEILERT FUNERAL HOMES: K.C., MO.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>11-12-59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Neva Minshall</i>
--	--	--

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF Robert F. Goodwin MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

~~DATE~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Jack P. Moore

Licensed Embalmer No. 4729

P. O. Address Kansas

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.