

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-001309

FILED VS FEB 2 1960

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 15

1. PLACE OF DEATH a. COUNTY <u>HOWELL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>HOWELL</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WEST PLAINS</u>		Length of stay in lb <u>30 yrs.</u>		c. CITY OR TOWN <u>WEST PLAINS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Y</u> <u>Y</u>				d. STREET ADDRESS <u>S. SUBURBS</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARVEY HARDEN BELL</u>				4. DATE OF DEATH Month Day Year <u>1-13-60</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12-13-1881</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>X</u>		11. BIRTHPLACE (City and state or country) <u>douglas co., mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13a. FATHER'S NAME <u>LEWIS BELL</u>			13b. MOTHER'S MAIDEN NAME <u>ANGELINE MARTIN</u>			14. NAME OF HUSBAND OR WIFE <u>X</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Y</u>		16. SOCIAL SECURITY NO. <u>YES</u>		17. INFORMANT <u>ARTHUR BELL, WEST PLAINS, MO</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRRHOSIS OF LIVER</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>(1) ARTERIOSCLEROSIS (2) ARTERIO SCLEROTIC HEART DISEASE</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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. p.m. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>10-31-59</u> to <u>1-13-60</u> and last saw him alive on <u>1-13-60</u> Death occurred at <u>10:00 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Dr. Wiles, M.D.</u>				22b. ADDRESS <u>West Plains, Mo.</u>		22c. DATE SIGNED <u>1-19-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		23b. DATE <u>1-16-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		23d. LOCATION (City, town, or county) (State) <u>WEST PLAINS MO</u>	
24. FUNERAL DIRECTOR <u>ROBERTSONS, WEST PLAINS, MO</u>				25. DATE RECD. BY LOCAL REG. <u>1-26-60</u>		26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *D. A. Roberts*

Licensed Embalmer No. 343

P. O. Address West

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.