N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

39
3
6

REC'D MAR 13 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

6559
Do not use this space.

1. PLACE OF DEATH
(a) County Greene
(b) Township
(c) City Springfield Mo
Registration District No. 316
Primary Registration District No. 2001
Registered No. 157
(d) Street No. Community Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 4 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME NANCY BELL
(a) Residence, No. 1047 Sherman Ave St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Colored
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug - 1880.
7. AGE Years Est 59 Months Days If LESS than 1 day, ...hrs. or ...min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Domestic
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Texas

FATHER
13. NAME Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unk

MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unk

17. INFORMANT Mrs. Hines
(ADDRESS) 1005 Sherman

18. BURIAL, CREMATION, OR REMOVAL
PLACE Lincoln Memorial DATE 2-24- 1939

19. FUNERAL DIRECTOR (NAME) H.V. Smith
(ADDRESS) 702 - N - Jefferson

20. FILED Feb 23 1939 Chas A Gloge MD
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) - 2 - 20 - 1939

22. I HEREBY CERTIFY, That I attended deceased from 2/13/1939, to 2/20/1939
I last saw him alive on 2/19/1939. Death is said to have occurred on the date stated above, at 2.30 P.m.
The principal cause of death and related causes of importance were as follows:

Intestinal Obstruction — Date of onset 2/12/39

Other contributory causes of importance: Chr myocarditis

Name of operation ... Date of ...
What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ... Date of injury ..., 19...
Where did injury occur? ...
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify No
(Signed) R. E. Jenkins, M. D.
(Address) 330 E College St
Springfield, Mo

(Licensed Embalmer's Statement on Reverse Side)

43C

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, ...
Herbert V Smith, or by .....

Registered Apprentice No....., working under my personal supervision.

Signed Herbert V Smith

Licensed Embalmer No. 3324

P. O. Address 702 - N - Jeffer

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

6559
Do not use this space.

1. PLACE OF DEATH
(a) County Greene — Registration District No. 318
(b) Township — Primary Registration District No. 2001 — Registered No. 157
(c) City Springfield — (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Nancy Bell
(a) Residence, No. ..... St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BELOW.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Col
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE — Years est 59 — Months — Days — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE ....., 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED ....., 19 ..... Local Registrar.

SUPPLEMENTAL

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2 - 20 1939

22. I HEREBY CERTIFY, That I attended deceased from 2/17/, 19..., to 2/20/, 1939, I last saw him alive on 2/19/, 1939. Death is said to have occurred on the date stated above, at 2:30 P m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Intestinal Obstruction	about
due to Fecal Impaction	2/15/39

Other contributory causes of importance:
Chr myocarditis 93
Chr Constipation

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) O. E. Jenkins, M. D.
(Address) Springfield Mo