

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

504-9-19-38

MARGIN RESERVED FOR BINDING

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.

1893
1893

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

31528
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township Kaw Primary Registration District No. 1002
 (c) City Kansas City or St. Mary's Hosp. (d) Street No. _____
 (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.
 4 0 0

2. PRINT FULL NAME Marguerite C. Bell
 (a) Residence, No. Lexington, Mo. 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 Fe. 4. COLOR OR RACE Wh. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widow.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov., 22nd. 1902

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
36 9 23

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housework
 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) Lexington, Mo.

FATHER
 13. NAME William Palmer
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lexington Mo.

MOTHER
 15. MAIDEN NAME Elnora Moore
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lexington Mo.

17. INFORMANT (ADDRESS) Lawrence Palmer
St. Francis Hotel 9th & Hill

18. BURIAL, CREMATION, OR REMOVAL PLACE Lexington Mo. DATE 9/19 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Quirk & Tobin
Linwood & Main

20. FILES Sept 17 1939 M. M. Brown
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept., 15, 1939

I HEREBY CERTIFY, That I attended deceased from July 20 1939, to Sept. 15 1939
 I last saw h. alive on Sept. 15 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:
Sepsicemia
139 B
 Other contributory causes of importance:
Diffuse peritonitis - result of gastric infection
Mixed infection - Chylo unknown
Septicemia & pneumonia
 Name of operation laparotomy & drainage Date of July 31-39
 What test confirmed diagnosis? Physician's case were an autopsy? No.

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) Dr. B. Norbury, M. D.
 (Address) Professional Bldg
K. C. Mo.

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

Signed..... *Maurice M. Quirk*
Licensed Embalmer No..... *7276*
P. O. Address.....

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