

MAY 15 1940 399

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 1692

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town _____
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Florence Home for Colored Girls
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)

In this community _____
 years, months or days

3. (a) PRINT FULL NAME Robert Henry Bell 400

3. (b) If veteran, name war No B. (c) Social Security No. MO

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 21, 1940
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 23 If less than one day hr. _____ min. _____

9. Birthplace Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

12. Name Robert Henry Bell

13. Birthplace _____
 (City, town, or county) (State or foreign country)

14. Maiden name Bell
 (City, town, or county) (State or foreign country)

15. Birthplace Mo
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Helene Bell

(b) Address 2228 Campbell

17. (a) Burial (b) Date thereof 4-23-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Municipal Cem. Leads, Mo.

18. (a) Signature of funeral director W.A. Lohmeyer

(b) Address K.C. General Hospital No. 1

19. (a) 4-22-1940 (b) M. M. Brown
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. Florence Home for Colored Girls
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13
 year 1940 hour 4:00 minute _____ A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Terminal Bronchopneumonia Duration _____

Due to _____

Due to _____

Other conditions NONE
 (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy Terminal Bronchopneumonia

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) Means of injury _____

23. Signature J. C. [Signature] (M. D. or other) _____

Address General Hospital Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.

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.....

Licensed Embalmer No.....

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

13980
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township Kearney Primary Registration District No. 1007
 (c) City Kansas City (d) Street No. Lourence Home Registered No. 1692
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (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 Robert Henry Bell
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

4. SEX Male 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
23
 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 4/22 1940 M. M. Brown Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 13, 1940
 22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
Infarction of the brain
hypertension
arteriosclerosis
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 Date of onset _____
 Other contributory causes of importance: _____
 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) _____, M. D.
 (Address) _____

SUPPLEMENTARY

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.

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

