

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **14625**

Registration District No. **190**

Primary Registration District No. **4113**

Registrar's No. **20**

1. PLACE OF DEATH

(a) County **Clark**
(b) City or town **Kahoka**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **2**
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Clark**
(c) City or town **Kahoka**
(If outside city or town limits, write "RURAL")
(d) Street No. **0**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME **Laura Bell** **460**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married divorced **Married**

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

7. Birth date of deceased **Oct 18 1893**
(Month) (Day) (Year)

8. AGE: Years **46** Months **5** Days **13** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Housekeeping**

11. Industry or business _____

12. Name **Henry Nickel**

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

14. Maiden name **Eva Werkseger**

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

16. (a) Informant **Mr. Clinton Bell**
(b) Address **Kahoka Mo.**

17. (a) **Burial** (b) Date thereof **Apr. 3 - 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Kahoka Co.**
18. (a) Signature of funeral director **Puttunge Lind**
(b) Address **Kahoka Mo.**
19. (a) **Apr 3 - 1940** (b) **J. R. ...**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Apr** day **5** year **1940** hour **7:30** minute **10** M.

21. I hereby certify that I attended the deceased from **Apr 10** 19**40** to **Apr 1** 19**40** that I last saw him alive on _____ 19____ and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of the intestines**

Due to _____
Due to **46**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Carcinoma**
Of operations _____
Of autopsy _____

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? **174**

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

23. Signature **J. R. ...** (M. D. or other) _____
Address **Kahoka Mo.** Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

WRITE LEGIBLY - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 10

District File Number 5-40-1049

Date Filed MAY 14 1940

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 April-1-1940 Registered Apprentice No. _____ working under my personal supervision.

Signed Olis L. Lutting
Licensed Embalmer No. 29657
P. O. Address Lurray Mo

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.