

FILED MAY 17 1940

STANDARD CERTIFICATE OF DEATH

15566

State File No.

Registration District No.

Primary Registration District No.

Registrar's No.

1133

4587

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Canalou  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 years  
In this community 6 years  
years, months or days

3. (a) PRINT FULL NAME Lillie Bell 400  
8. (b) If veteran, name war: No. 8. (c) Social Security No.

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

6. (b) Name of husband or wife Sam Bell 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased March 8 1883  
(Month) (Day) (Year)

8. AGE: Years 57 Months 1 Days 16 If less than one day hr. min.

9. Birthplace Montgomery Co. Miss  
(City, town, or county) (State or foreign country)

10. Usual occupation farm Work

11. Industry or business i

FATHER { 12. Name John Allen

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

MOTHER { 14. Maiden name Unknown

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

16. (a) Informant Ed Willis

(b) Address Canalou, Mo.

17. (a) Burial (b) Date thereof 4/25/1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Madrid Co.

18. (a) Signature of funeral director John Allen

(b) Address Stanton, Mo.

19. (a) (Date received local registrar) (b) 5-11-40 (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County New Madrid  
(c) City or town Canalou Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. - (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24th  
year 1940 hour 3:00 minute a. M.

21. I hereby certify that I attended the deceased from 6-9-39  
to 4-24-40  
that I last saw him alive on 4-24-40  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction  
due to atherosclerosis

Other conditions hypertension  
(Include pregnancy within 3 months of death)

Due to atherosclerosis

Due to hypertension

Other conditions 38

Major findings: Of operations 38

Of autopsy none

Duration weeks  
PHYSICIAN 38  
Underline the cause to which death should be charged statistically.

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) (e) Means of injury \_\_\_\_\_

23. Signature W. Alexander (M. D. or other)  
Address Stanton Date signed 4-25-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 2,

District File Number 540-105

Date Filed 5/15/40

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 me

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed

John A. Curran

Licensed Embalmer No. 2941

P. O. Address St. Louis

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 15-366

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 1133

Primary Registration District No. 43-87

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town anahou  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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

Lillie Bell

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F

5. Color of race col

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_

(Month)

(Day)

(Year)

8. AGE:

Years 37 Months 1 Days 16

If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (Burial, cremation, or removal)

(b) Date thereof \_\_\_\_\_

(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 6-11-1940 (b) \_\_\_\_\_ (Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month apr day 24 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_ that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: 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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature M. G. Anderson (M.D. or other) \_\_\_\_\_

Address Sturgeon \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL COPY

