

5-17-40
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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28615

Registration District No. 347

Primary Registration District No. 3018

Registrar's No.

+2
4
2

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

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Chinton mo
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution:
In this community all life (Specify whether years, months or days)

3. (a) PRINT FULL NAME ANNABELLE BELTON
(b) If veteran, name war
(c) Social Security No. 435

4. Sex Fem
5. Color or race white
(a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife Richard
6. (c) Age of husband or wife if alive years 30 1864
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 76 Months 0 Days 14 If less than one day hr. min.

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

10. Usual occupation Home work

11. Industry or business
MOTHER { 12. Name Eli
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 Wm Belton
(b) Address Chinton mo

17. (a) Burial (b) Date thereof 8-16-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Igo cem

18. (a) Signature of funeral director Consolus + Belton
(b) Address Chinton mo

19. (a) 8-17-40 (b) (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State mo (b) County Henry
(c) City or town Chinton mo
(If outside city or town limits, write "RURAL")
(d) Street No. 301 West Franklin
(If rural, give location)
(e) If foreign born, how long in U. S. A. life years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 14
year 1940 hour 11 minute 15 PM.
21. I hereby certify that I attended the deceased from 3-6, 1940 to 8-14, 1940
that I last saw her alive on 8-13, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage Duration 2 weeks

Due to: Chronic myocarditis 2-3 yrs

Due to:

Other conditions: (Include pregnancy within 3 months of death) 920

PHYSICIAN
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) Means of injury
23. Signature Eugene D. Howell (M. D. or other) M.D.
Address Chinton mo Date signed 8-15-40

RECEIVED

District Health Officer No. 7,

District File Number

9-40-1358

Date Filed

9-16-40

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

J. E. Conzalez

Licensed Embalmer No.....

1891

P. O. Address.....

Clinton 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28616-2

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 347

Primary Registration District No. 3018

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Clinton Mo.
(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.....
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Annabelle Belton

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced, wid
6. (b) Name of husband or wife Richard 6. (c) Age of husband, or wife, if alive..... years
7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 76 Months 0 Days 14 If less than one day..... min.

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

10. Usual occupation Housewife

11. Industry or business.....

MOTHER (12) Name Jackson, Eli
(13) Birthplace Missouri (City, town, or county) (State or foreign country)
(14) Maiden name Mary M. Howard
(15) Birthplace Mo. (Not seen) (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. C. Powell
(b) Address E. Franklin St. Clinton Mo.

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director Consalus + Reck
(b) Address Clinton Mo.

(19) (a) Sept 17, 1940 (b) Dr. J. R. Hamilton
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 14
year 1940 hour..... minute..... 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.....

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) (2) Means of injury.....

23. Signature Eugene W. Shull (M. D. or other)
Address Clinton Mo. Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

