

No. 2  
A-5-43  
5-17-39  
X36671

18204

State File No. ....

FILED JUN 8 1944  
Registration District No. 8400A

Primary Registration District No. 5568

Registrar's No. 113

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Fairmount Station, Kento  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
10622 Kentucky Blue Sup.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 20 years. (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 49

(c) City or town Kento (Fmt. Sta.)  
(If outside city or town limits, write "RURAL")

(d) Street No. 10622 Kentucky Blue Sup.  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary S. Bell

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex Female 5. Color or race white

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

6. (b) Name of husband or wife John Bell 6. (c) Age of husband or wife if alive 91 years

7. Birth date of deceased January 24 1875  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28  
year 1944 hour 3 minute 20 P.M.

21. I hereby certify that I attended the deceased from 8/2 1943 to 7/28 1944  
that I last saw her alive on 7/28 1944  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
69 3 4 hr. min.

Immediate cause of death Acute Myocarditis

Due to Epithelioma

Due to Coclelexia

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

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

10. Usual occupation House wife

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

12. Name Unknown Rogers

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

14. Maiden name Unknown

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

16. (a) Informant John Bell

(b) Address 10622 Kentucky

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 1 - 1944  
(Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn

18. (a) Signature of funeral director George C. Carson

(b) Address Independence, Mo.

19. (a) 5-1-44 (Date received local registrar) (b) Jamew Ross (Registrar's signature)

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) (c) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address 616 WEST M. D. Date signed 5/1/44

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

MOTHER FATHER

1163

**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 *Hayden C. Carson*  
Licensed Embalmer No. *41199*  
P. O. Address *Independence,*

**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, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. *June**June*Registration District No. *146*Primary Registration District No. *2268*Registrar's No. *113*

## 1. PLACE OF DEATH:

- (a) County *Jackson*  
 (b) City or town *Fairmont Station*  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: *Stue Imp.*  
 (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 *Mary S. Bell*

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 *in*

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

7. Birth date of deceased *Jan 24 1871*  
(Month) (Day) (Year)

8. AGE: Years *69* Months *3* Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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

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

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

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

19. (a) \_\_\_\_\_ (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *April* day *28*  
year *1944* hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;

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

Immediate cause of death *acute myocarditis*

*epithelioma*

Due to *cachexia*

Due to *R. lower lip c. marked adenopathy of rt. gl. of neck*

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

Major findings:  
Of operations \_\_\_\_\_

Of autopsy *USA*

## PHYSICIAN

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 *Quittman* (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTAL

18204