

S. No. 2
M-8-43
7-5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33893**

FILED OCT 23 1945
Registration District No. **146**

Primary Registration District No. **3026**

Registrar's No. **259**

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Independence
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
407 East Lexington
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 75 Years
years, months or days

3. (a) PRINT FULL NAME Malisa D. Bell
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 Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct. 10 1865
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>8</u>	<u>26</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name Joseph Pen
13. Birthplace Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Lottie Harland
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Amy Echoels
(b) Address 400 E. Lexington, Independence

17. (a) Burial (b) Date thereof Sept. 8 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Jones Cemetery

18. (a) Signature of funeral director George C. Carson
(b) Address Independence Mo.

19. (a) 9-7-45 (b) James Ross
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Independence
(If outside city or town limits, write "RURAL")
(d) Street No. 407 east Lexington
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 9 day 6
year 1945 hour 8:30 minute A 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 Coronary Arteriosclerosis
Due to status Schumi

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy no
Heart & Injection

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 stroke
23. Signature James Ross (M. D. or other) _____
Address 1424 Jefferson Date signed 9-6-45

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

1153

(Licensed Embalmer's Statement on Reverse Side)

70211

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 O. K. McFarland
Licensed Embalmer No. 4397
P. O. Address Independence 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, fact should be so stated above.