

FILED APR 15 1946
Registration District No. 356

Primary Registration District No. 62094521

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Houston
(c) Name of hospital or institution: 1
(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 Timothy Wayne Bell

3. (b) If veteran, name war _____ 3. (c) Social Security No. 1

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct. 6 1945
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
		<u>4</u>	<u>21</u>	hr. _____ min. _____

9. Birthplace Cincinnati Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation child

11. Industry or business _____

12. Name Pertis Bell
13. Birthplace Sumner Ky
14. Maiden name Wanda Hillier
15. Birthplace Houston Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Wanda Bell

(b) Address Houston Mo

17. (a) Burial (b) Date thereof 8/19/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Houston

18. (a) Signature of funeral director Raymond D. Elliott

(b) Address Houston Mo.

19. (a) 3-13-1946 (b) Minnie Craig
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Texas
(c) City or town Houston Mo
(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 Feb. day 27 year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on Debat see and that death occurred on the date and hour stated above.

Immediate cause of death pneumonia Duration _____

Due to unknown

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

22. If death was due to external cause, fill in the following:

(c) 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 Raymond D. Elliott (M. D. or other)

Address Houston Date signed 3-5-46

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED
District Health Officer No. 5
District 446
Date Filed 11/13/46

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 Frank E. Hood
Licensed Embalmer No. 4024
P. O. Address Houston, 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.

April
27

Registration District No. *356*

Primary Registration District No. *4521*

Registrar's No. *27*

1. PLACE OF DEATH:
(a) County *Texas Houston*
(b) City or town *Texas Houston*
(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 _____)

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 _____

3. (a) PRINT FULL NAME *Timothy W. Bell*
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month *4* year *1946* hour _____ minute _____ M. *27*
21. I hereby certify that I attended the deceased from _____ 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 _____

4. Sex *M* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *5*
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased: *Oct 6* (Month) (Day) (Year)
8. AGE: Years _____ Months _____ Days _____ (If less than one day) _____ hr. _____ min.
9. Birthplace *Ohio* (City, town, or county) (State or foreign country)

Due to *Sobury. Pneumonia*
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy *108*
Duration _____

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)

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 *J. B. Womack* (M. D. or other) _____
Address _____ Date signed _____

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

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

SUPPLEMENTARY

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

MOTHER FATHER

10880

11978