S. No. 2
—12-45
5-17-39
I X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 22 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30380

Registration District No. 42 | Primary Registration District No. 1000 | Registrar's No. 1108

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2620 Locust st /
(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 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Buchanan 11
(c) City or town St.Joseph /
(If outside city or town limits, write "RURAL")
(d) Street No. 2620 Locust 7
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MYRTLE BELL
3. (b) If veteran, name war —
3. (c) Social Security No. ✓
4. Sex Female 3
5. Color or race Negro
6. (a) Single, widowed, married, divorced Widowed 2
6. (b) Name of husband or wife Phullip Bell
6. (c) Age of husband or wife if ~~alive~~ ..... years
7. Birth date of deceased Dec. (Month) 26 (Day) 1895 (Year)

8. AGE:	Years	Months	Days	If less than one day
51 ✓	51	8	15	hr. min.

9. Birthplace Center Point Ark. /
(City, town, or county) (State or foreign country)
10. Usual occupation House Wife
11. Industry or business
FATHER
12. Name Willie Wesson
13. Birthplace Center Point Ark. /
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Isabella Vaughn
15. Birthplace Center Point Ark. /
(City, town, or county) (State or foreign country)
16. (a) Informant Mrs Jewell Harris, niece
(b) Address 217 E. 4th Hope Ark.
17. (a) Ashland (Burial, cremation, or removal) (b) Date thereof Sept (Month) 15 (Day) 1947 (Year)
(c) Place: burial or cremation Ashland
18. (a) Signature of funeral director Beatrice Gray
(b) Address 912 Pacific St
19. (a) 9-16-47 (Date received local registrar) (b) E. C. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 11
year 1947 hour 5 minute 30 p.M.
21. I hereby certify that I attended the deceased from July 7, 1947 to Sept. 11, 1947
that I last saw her alive on Sept. 11, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Terminal Lobar Pneumonia	5 days
Due to Sarcoma of Uteris	Dont know
Due to	
Other conditions Progressive Anemia (Include pregnancy within 3 months of death)	2 month

Major findings:
Of operations
Of autopsy

48B

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?
(Specify type of place)
While at work? (e) Means of injury 0
23. Signature J. D. Sexton (M. D. ~~or other~~)
Address 1923 Messanie St. Date signed 9-12-47
St Joseph, Mo

(Licensed Embalmer's Statement on Reverse Side)

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 Earl A Clark

Licensed Embalmer No. 4338

P. O. Address St Joseph 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.