

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43694**

DECEASED DEC 18 1951

REG. DIST. NO. **324**

PRIMARY REG. DIST. NO. **3072**

Registrar's No. **221**

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Fitzgibbon Hospital		d. STREET ADDRESS (If rural, give location) 460 South Ellsworth	
3. NAME OF DECEASED (Type or Print) Wilber Angelo Belshe			4. DATE OF DEATH (Month) (Day) (Year) Dec. 7 1951
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 9-1900
9. AGE (In years last birthday) 50		10. MONTH 11	10. DAY 28
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brooks Truck Lines		10b. KIND OF BUSINESS OR INDUSTRY Drove Truck	11. BIRTHPLACE (State or foreign country) Spring Garden, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME John Belshe	
13b. MOTHER'S MAIDEN NAME Anna Spalding		14. NAME OF HUSBAND OR WIFE Addie Hood Belshe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 487-01-4450	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Wilber A. Belshe		ADDRESS Marshall, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage	
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 hours	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 331X	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from Dec 7, 1951 , to Dec 7, 1951 , that I last saw the deceased alive on Dec 7, 1951 , and that death occurred at 7 p. m. , from the causes and on the date stated above.	
23a. SIGNATURE James A. Reid, D. M.D.		23b. ADDRESS Marshall, Mo.	
23c. DATE SIGNED 12-8-51		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 12/19/51		24c. NAME OF CEMETERY OR CREMATORY Ridge Park	
24d. LOCATION (City, town, or county) (State) Marshall, Mo.		DATE REC'D BY LOCAL REG. Dec. 9-1951	
REGISTRAR'S SIGNATURE Widney F. Gray		25. FUNERAL DIRECTOR'S SIGNATURE (ADDRESS) Leeleie Swamy Marshall, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED DEC 17 1951

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed DEC 17 1951

APR 12 1952

RECEIVED

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed J. Leslie Sweeney

Licensed Embalmer No. 8-2-15

P. O. Address Marshall, Miss.

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.