

FILED DEC 12 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35988

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1273

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY OR TOWN <u>St. Joseph</u>	c. LENGTH OF STAY (If in this place) <u>82 yrs</u>	c. CITY OR TOWN <u>St. Joseph</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Kirkman Nursing Home (Elliott's) 1313 North 10th Street</u>		STREET ADDRESS (If rural, give location) <u>5646 South 2nd Street</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>THOMAS</u>	b. (Middle) <u>BENTON</u>	c. (Last) <u>BELL</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 29 1955</u>
-------------------------------------	--------------------------	---------------------------	-----------------------	---

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>October 1, 1864</u>	9. AGE (In years last birthday) <u>91</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
--------------------	-------------------------------	---	---	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Grocer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Indiana</u>	12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
--	--	---	---

13a. FATHER'S NAME <u>Henry Bell</u>	13b. MOTHER'S MAIDEN NAME <u>Armilda Simpson</u>	14. NAME OF HUSBAND OR WIFE <u>Martha Ann Bell (Deceased)</u>
--------------------------------------	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Nellie Malson</u>	ADDRESS <u>St. Joseph, Mo.</u>
--	-----------------------------------	---	--------------------------------

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		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Cerebral Hemorrhage</u>		Ukn.
	ANTECEDENT CAUSES DUE TO (b) <u>Generalized Arteriosclerosis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS <u>Senility &amp; General Debility</u>			<u>331X</u>
Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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 8-5, 1955, to 11-29, 1955, that I last saw the deceased alive on 11-29, 1955, and that death occurred at 3:45 Pm., from the causes and on the date stated above.

23a. SIGNATURE <u>H F Mundy</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>2801 Sacramento St. Joseph, Missouri</u>	23c. DATE SIGNED <u>11-30-55</u>
---	--	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Dec. 1, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>
---	-------------------------------	---	--

DATE REC'D BY LOCAL REG. <u>Dec 6, 1955</u>	REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>	485	25. FUNERAL DIRECTOR'S SIGNATURE <u>Stamey Funeral Home</u>	ADDRESS <u>St. Joseph, Mo.</u>
---	--	-----	---	--------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

---

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.....  
Signature of Student Embalmer

Signed *Charles E. Bennett*

Licensed Embalmer No. *467*

P. O. Address *St. Joseph*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.