

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

23344

State File No. _____

FILED JUL 30 1956

BIRTH NO. 45156-56 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 667-E

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE <u>MO</u> b. COUNTY <u>GREENE</u>		
b. CITY (If outside corporate limits, write RURAL and give township) <u>SPRINGFIELD</u>		c. LENGTH OF STAY (In this place) <u>2 HRS</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>SPRINGFIELD MO</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BURGE</u>			d. STREET ADDRESS (If rural, give location) <u>1040 ELM ARCADE</u>		

3. NAME OF DECEASED (Type or Print) a. (First) <u>FRANK</u> b. (Middle) <u>LEE</u> c. (Last) <u>BELL</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 19 1956</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>July 19 - 1956</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 2 HRS. Hours Min. <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>SPRINGFIELD MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>

13a. FATHER'S NAME <u>CHIFFORD BELL</u>	13b. MOTHER'S MAIDEN NAME <u>VIRGINIA HURD</u>	14. NAME OF HUSBAND OR WIFE			
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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. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>CHIFFORD BELL SPRINGFIELD</u>			
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Anoxia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Prematurity (24 weeks) Respiratory Center failure</u> DUE TO (c) <u>Premature Rupture membranes 4 days</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) <u>7615</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 July 19, 1956, to _____, 19____, that I last saw the deceased alive on July 19, 1956, and that death occurred at 4:15 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>A. Med. White M.D.</u>	23b. ADDRESS <u>609 Cherry Springfield</u>	23c. DATE SIGNED <u>289956</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>7-22-1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>MARSHFIELD MARSHFIELD MO</u>	24d. LOCATION (City, town, or county) (State) <u>MARSHFIELD MO</u>
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DATE REC'D BY LOCAL REG. <u>7-24-56</u>	REGISTRAR'S SIGNATURE <u>Edith Williamson</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>BARBER EDWARDS MARSHFIELD</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

0.300
0.48

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

Not Embalmed

Licensed Embalmer No. _____

P. O. Address _____

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.