

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20684

STATE FILE NUMBER

FILED JUN 24 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 553

Health,
Welfare
Public
Service

300
1-56

ALL diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Tennessee b. COUNTY DAVIDSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Nashville Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Medical Center for Federal Prisoners		Length of stay in 1b 571 days	d. STREET ADDRESS (If outside, give location) 1306 Charlotte Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Robert Middle --- Last Bell			4. DATE OF DEATH Month June Day 16 Year 1957
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Hotel	9. AGE (In years last birthday) 62 IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS. Hours 0 Min. 0
11. BIRTHPLACE (City and state or country) Nashville, Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Bell		14. MOTHER'S MAIDEN NAME Mary Douglas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 410-80-736	17. INFORMANT FILE: M.C.F.P. Springfield, Mo. Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 2 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Thrombocytopenia			2 weeks
DUE TO (c) Chronic lymphocytic leukemia			2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2040			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Hour --- Month --- Day --- Year --- a. m. --- p. m. ---		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) ---	
20e. CITY, TOWN, OR LOCATION ---		COUNTY --- STATE ---	
21. I attended the deceased from 11-22-55 to 6-16-57 and last saw him her alive on 6-16-57 Death occurred at 2:55 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) E. C. Rinck, M.D. Clinical Director	
22b. ADDRESS Medical Center for Fed. Prisoners: Springfield, Mo.		22c. DATE SIGNED 6-17-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-18-57	23c. NAME OF CEMETERY OR CREMATORY ---	23d. LOCATION (City, town, or county) (State) Nashville, Tenn.
24. FUNERAL DIRECTOR AYRE-@OODWIN, Inc., Springfield		25. DATE RECD. BY LOCAL REG. 6-18-57	26. REGISTRAR'S SIGNATURE Eartha Williamson

(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 Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Lynn T. Swadley*

Licensed Embalmer No. *48*

P. O. Address *Spring*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.