

Health,
Public
Service

00
57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

FILED AUG 26 1957

STANDARD CERTIFICATE OF DEATH

42

57 0 27 50 8
STATE IDENTIFICATION NUMBER
1000 REGISTRAR'S NO. 898

Registration District No. Primary Registration District No. Registrar's No.

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 (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Joseph</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jackson Nursing</u>		Length of stay in 1b <u>1 WEEK</u>	d. STREET ADDRESS (If outside, give location) <u>2017 Sylvania St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Harry</u> Last <u>Bell</u>			4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1874</u>
9. AGE (In years last birthday) <u>83 yrs.</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>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>St. Joseph, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>John Bell</u>	
13b. MOTHER'S MAIDEN NAME <u>Anna M. Harris</u>		14. NAME OF HUSBAND OR WIFE <u>Ada Bell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes Spanish-American</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. Joyce Drake</u> Address <u>410 S. 16th. St.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broken Compensation</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Ukn.</u> <u>Ukn.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<u>1200</u>	
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 _____ a.m. _____ p.m. _____ Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>7-26-57</u> to <u>8-13-57</u> and last saw me him alive on <u>8/12/57</u> Death occurred at <u>8-13, 57-6:55P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>R. M. Melaney M.D.</u>	
22b. ADDRESS <u>Social Welfare Board</u> <u>10th & Olive, St. Joseph, Mo.</u>		22c. DATE SIGNED <u>8/14/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-17-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ashland Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Joseph Mo.</u>
24. FUNERAL DIRECTOR <u>Beatrice Gray</u> ADDRESS <u>City 812 Pacific</u>		25. DATE RECD. BY LOCAL REG. <u>Aug. 19, 1957</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</u>			

(Licensed Embalmer's Statement on Reverse Side)

3 2 8 7 3 2

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 *John T. Miles*

Licensed Embalmer No. *3446*

P. O. Address *Atchison, Kan.*

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.