

FILED FEB 10 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

238

STATE FILE NUMBER

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 97

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		d. STREET ADDRESS (If outside, give location) 1011 No. 13th St.	
3. NAME OF DECEASED (Type or print) First CHARLES Middle HAMILTON Last BELL		4. DATE OF DEATH Month January Day 23 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June, 4, 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Garage	9. AGE (In years last birthday) 85 Years
13a. FATHER'S NAME William H. Bell		13b. MOTHER'S MAIDEN NAME Ida Denton	11. BIRTHPLACE (City and state or country) Maryland
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. None	12. CITIZEN OF WHAT COUNTRY? U. S. A
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage		14. NAME OF HUSBAND OR WIFE Ruth E. Bell (deceased)	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		17. INFORMANT Mr. Earl Bell, St. Joseph, Missouri	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) 331X		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	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 Jan 10 58 to Jan 23-58 and last saw ^{her} _{him} alive on Jan 22-58 Death occurred at 5.30 A. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Clarence C. [Signature]</i> (Degree or title)		22b. ADDRESS St Joseph Mo	22c. DATE SIGNED 1-24-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 25, 1958	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph Missouri
24. FUNERAL DIRECTOR Stammy Fun. Home ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Feb. 5, 1958	26. REGISTRAR'S SIGNATURE <i>Mrs. Robert Fulton</i>

(Licensed Embalmer's Statement on Reverse Side)

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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. *4679*

P. O. Address *St. Joseph, Mo.*

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.