

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044887

STATE FILE NUMBER

FILED DEC 29 1958

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 431

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <u>MARION</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MARION</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HANNIBAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>HANNIBAL</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>2218 SPRUCE</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>2218 SPRUCE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JESSE</u> Middle <u>BELL</u> Last <u>BELL</u>			4. DATE OF DEATH Month <u>DEC</u> Day <u>15</u> Year <u>1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGR</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 16, 1891</u>	9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUSTODIAN Post Office</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>POST OFFICE</u>		11. BIRTHPLACE (City and state or country) <u>HANNIBAL MO</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13a. FATHER'S NAME <u>SIMON BELL</u>		13b. MOTHER'S MAIDEN NAME <u>BELL FOSTER</u>	
14. NAME OF HUSBAND OR WIFE <u>ELIZABETH BELL</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>ELIZABETH BELL</u>		Address <u>2218 SPRUCE</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>Coronary infarction</u>					INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive cardio vascular disease</u>					<u>6 months</u>
DUE TO (c) _____					
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.)			
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 <u>Aug 13, 1958</u> to <u>Dec 15, 1958</u> and last saw him alive on <u>Nov 19, 1958</u> Death occurred at <u>8:30 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M. D.</u>			22b. ADDRESS <u>707 Bdwy Hannibal, Mo.</u>		22c. DATE SIGNED <u>12-22-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>12/20/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Robinson Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Hannibal, Marion Mo.</u>
24. FUNERAL DIRECTOR <u>Geo E Roberts</u>		ADDRESS <u>[Address]</u>		25. DATE RECD. BY LOCAL REG. <u>12/22/58</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

f 0

RECEIVED DEC 22 1958

MARION CO. HEALTH DEPT.

DATE FILED DEC 22 1958

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 Geo E Roberts .....

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