

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017600

FILED JUN 9 1959 Registration District No. 149 Primary Registration District No. 1002 STATE FILE NO. 2328 Registrar's No.

1. PLACE OF DEATH a. COUNTY JACKSON			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 400 EAST 79th. TERR.		Length of stay in lb 8 yrs.	d. STREET ADDRESS 400 EAST 79th. TERRACE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last REUBEN CARMAL BELL			4. DATE OF DEATH Month Day Year MAY 8, 1959		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 7, 1906	9. AGE (In years last birthday) 52	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REALTOR		10b. KIND OF BUSINESS OR INDUSTRY R. C. BELL REALESTATE CO.		11. BIRTHPLACE (City and state or country) EUPORA, MISSISSIPPI	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME Van Johnson		13b. MOTHER'S MAIDEN NAME Addie Lamb	
14. NAME OF HUSBAND OR WIFE KATHERINE AGNES BELL		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. 442-03-0990	
17. INFORMANT Mrs. KATHERINE AGNES BELL-KANSAS CITY, MO.		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>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH 18 months	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) H200		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 WORK <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>June 1957</u> to <u>May 8, 1959</u> and last saw him alive on <u>May 7, 1959</u> Death occurred at <u>4:00 P. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Harold W. Voth, M.D.</u>		(Degree or title) D		22b. ADDRESS <u>201 Plaza Med Bldg 315 Nichols Rd. N.C. Mo.</u>	
22c. DATE SIGNED <u>May 9, 59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/11/1959	
23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery		23d. LOCATION (City, town, or county) Kansas City, Missouri			
24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS-KANSAS CITY, MO.		1331 BRUSH ADDRESS CREEK BLVD.		25. DATE RECD. BY LOCAL REG. 5-11-59	
26. REGISTRAR'S SIGNATURE <u>Gene Marshall</u>					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Harold W. Voth

MEDICAL CERTIFICATION

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 *Norman W. Larson* .....

Licensed Embalmer No. *4889*.....

P. O. Address *N. C., N.C.*.....

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.