

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **23893**
6166

AUG 1 1939 791

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

1. PLACE OF DEATH: **1008**

(a) County _____

(b) City or town **St. Louis**

(c) Name of hospital or institution: **Homer Phillips Hospital**

(d) Length of stay: In hospital or institution **Since July 4, 1939**

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____

(c) City or town **St. Louis**

(d) Street No. **2800a Market**

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Robert Bess**

3. (b) If veteran, name war _____

3. (c) Social Security No. **490-03-9539**

4. Sex **M** 5. Color or race **C** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Beatrice Bess** 6. (c) Age of husband or wife if alive **48** years

7. Birth date of deceased **January 1 1879**

8. AGE: Years **60** Months **6** Days **7** If less than one day _____ hr. _____ min.

9. Birthplace **Missouri**

10. Usual occupation **Laborer**

11. Industry or business _____

MOTHER FATHER { 12. Name **unknown David Bess**

13. Birthplace **Mo. Va.**

14. Maiden name **unknown**

15. Birthplace **unknown**

16. (a) Informant's own signature **Beatrice Bess**

(b) Address **2800a Market Washington Park**

17. (b) Date thereof **July 15, 1939**

(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **Jas. Harrison**

(b) Address **2906 Lafayette**

19. (a) **JUL 15 1939** (b) **J. B. Bredich**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **8** year **1939** hour **4** minute **30** P. M.

21. I hereby certify that I attended the deceased from **July 4, 1939** to **July 8, 1939** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage with hemiplegia**

Hypertensive heart disease; chronic nephritis

Due to _____

Due to _____

Other conditions _____

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury **1**

23. Signature **H. J. Lyman** (M. D. or other) _____

Address **266 1/2 North 1st** Date signed **7-10-39**

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Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed James H. Harrison
Licensed Embalmer No. 760
P. O. Address 2906 Lawton

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 this body is not embalmed, above space should be left blank.