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M-8-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39148

State File No. _____

FILED JAN 19 1945
Registration District No. _____

Primary Registration District No. 106

Registrar's No. 11076

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County _____
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Enroute to City Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution h
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Herman Belk
 (b) If veteran, name war Nil
 (c) Social Security No. Unknown

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 (b) Name of husband or wife Cecil Belk
 (c) Age of husband or wife if alive 32 years
 7. Birth date of deceased March 30 1905
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>39</u>	<u>9</u>	<u>2</u>	hr. _____ min.

9. Birthplace Iberia Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Sander
 11. Industry or business Missouri Wood Heel Co.

MOTHER FATHER {
 12. Name James Belk
 13. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)
 14. Maiden name Alice Shackelford
 15. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Cecil Belk
 (b) Address 3015 Wisconsin Ave.
 17. (a) Burial (b) Date thereof 12-26-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Lawn Cemetery
 18. (a) Signature of funeral director Albert H. Hoppe
 (b) Address 4700 Washington Blvd.

19. (a) DEC 27 1944 (b) J. J. Brudick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County _____
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 3154A Iowa
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 22
 year 1944 hour 10 minute 15 a.m.
 21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h_____ alive on _____, 19____;
 and that death occurred on the date and hour stated above

Immediate cause of death _____
Self administered at his home
Dec 22 - Dec 1944 about
10:15 a.m.

Due to _____
163.8.?
 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

PHYSICIAN

 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) suicide
 (b) Date of occurrence Dec 22 1944
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
 While at work? _____ (e) Means of injury 60 above
 23. Signature Albert H. Hoppe (M. D. or other) _____
 Address _____ Date signed 12/23

11076
9/20/77

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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 *John Agnoski*
Licensed Embalmer No. *3378*

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 this body is not embalmed, fact should be so stated above.