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ev. 5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JAN 31 1945

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 45  
Registrar's No. 755

Registration District No. 318 Primary Registration District No. 1003

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:  
Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 41 Days  
(Specify whether  
In this community.....  
years, months or days)

3. (a) PRINT FULL NAME Dennis James Bell  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced ( )  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased. 11 8 44  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
1 4 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name Cleatus Bell  
13. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Bernice Bradley  
15. Birthplace Carruthersville Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mary T. Dwall  
(b) Address 2601 N. Whittier Street

17. (a) (b) Date thereof JAN 25 1945  
(Burial, cremation, or other) (City or town) (County) (State)  
CITY CEMETERY

18. (a) Signature of funeral director V. B. Hudson  
(b) Address City Health Dept

19. (a) JAN 21 1945 (b) J. F. Bredeck  
(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. 709 N. Ewing Apt. 15  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 19  
year 44 hour 5 minute 55 p.M.  
21. I hereby certify that I attended the deceased from 11 - 8  
19 44 to 12 - 19 19 44  
that I last saw h. im alive on 12 - 19 19 44  
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration  
Due to Unknown  
Due to Unknown  
Other conditions (Include pregnancy within 3 months of death)  
Major findings:  
Of operations.....  
Of autopsy As above

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).....  
(b) Date of occurrence.....  
(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?  
While at work?..... (Specify type of place) (e) Means of injury.....  
23. Signature William H. Linber (M. D. or other)  
Address 2601 N. Whittier St. Date signed 1-19-45

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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.....

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