

FILED MAR 5 1945  
Registration District No. \_\_\_\_\_

Primary Registration District No. 6076

Registrar's No. 558

1. PLACE OF DEATH:

(a) County St. Louis Lemay Mo  
(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
9460 So. Broadway  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis Lemay  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5344a Easton Ave  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23  
year 1945 hour \_\_\_\_\_ minute 7:40 M.  
21. I hereby certify that I attended the deceased from July 23, 1945,  
to July 23, 1945;  
that I last saw her alive on July 23, 1945,  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Coronary occlusion  
Due to chronic vascular myocarditis  
Due to Rheumatic heart disease

Duration  
10 min  
several  
years  
several  
years

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 93c

PHYSICIAN  
Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

22. If death was due to external causes, fill in the following:  
(c) 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 Kevin D. Creelias (M. D. or other)  
Address 748 Lemay Dr Date signed 2/24/45

3. (a) PRINT FULL NAME Regina Catherine Bell  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Frank W. Bell 6. (c) Age of husband or wife if alive 25 years  
7. Birth date of deceased March 5th 1921  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>23</u>	<u>11</u>	<u>18</u>	_____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business At Home

MOTHER FATHER

12. Name Chas F. Day  
13. Birthplace Decatur Illinois  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Frank W. Bell Husband

(b) Address 5344a Easton Ave

17. (a) Burial (b) Date thereof Feb 27 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Olive Cemetery

18. (a) Signature of funeral director Peetz Bros

(b) Address 3029 Lafayette Ave

19. (a) FEB 26 1945 (b) Dr. S. M. ...  
(Date received local health officer) (Registrar's signature)

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

96000

**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 Frank J. Owens

Licensed Embalmer No. 2245

P. O. Address St Louis Mo

**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.**