

S. No. 2  
M-5-43  
7. 5-17-39  
I X38671

**FILED** AUG 27 1946

1003

7136

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town St. Louis, MO.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Parke Lane Hospital @  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days  
(Specify whether years, months or days)

In this community 4 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County \_\_\_\_\_

(c) City or town St. Louis, 4,  
(If outside city or town limits, write "RURAL")

(d) Street No. 1517 Hickory Lane  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ronnel Grace Bess

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Newborn

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug. 13 1946  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<u>4</u>	hr. min.

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

10. Usual occupation Newborn

11. Industry or business \_\_\_\_\_

12. Name Elwood Bess

13. Birthplace Campbell MO. O.  
(City, town, or county) (State or foreign country)

14. Maiden name Wanda Lee Wagster

15. Birthplace Leachville Ark.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Elwood Bess - Mother

(b) Address 1517 Hickory Lane City

17. (a) Burial (b) Date thereof 8-17-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cem

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette Avenue

19. (a) AUG 16 1946 (Date of local burial) J. T. Bredek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 16 year 1946 hour three minute thirty P.M.

21. I hereby certify that I attended the deceased from August 13 1946 to Aug. 16 1946 that I last saw him alive on Aug. 15 - P.M. 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Patent Foramen Ovale

Due to _____	Duration _____
Due to _____	Duration _____
Other conditions (include pregnancy within 3 months of death) _____	Duration _____
Major findings: Of operations _____	Duration _____
Of autopsy _____	Duration _____

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) (c) Means of injury \_\_\_\_\_

23. Signature J. D. Smith M.D. (M. D. or other) M.D. Address 4930 Lindell Blvd. Date signed 8/16/46

St. Louis - Mo

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

MOTHER FATHER

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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 C. W. Cooper

Licensed Embalmer No. 3838

P. O. Address 2301 Lafayette

**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.**