

No. 2
DM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 24 1946
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **31552**
Registrar's No. **7804**

Registration District No. _____ Primary Registration District 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 Barnes Hospital, 0
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 36 days
Specify whether
 In this community.....
 years, months or days

3. (a) PRINT FULL NAME John Edward Bell
3. (b) If veteran, N11 **(c) Social Security No.** 498-10-2328
 name war.....

4. Sex Male **5. Color or race** White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Maud Fleming Bell **6. (c) Age of husband or wife if alive** 57 years
7. Birth date of deceased October 1 1883
(Month) (Day) (Year)

8. AGE: Years 57 Months 11 Days 4 If less than one day
 hr. _____ min. _____

9. Birthplace Bonne Terre Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Supt. of County Infirmery

11. Industry or business _____
12. Name Frank K. Bell
13. Birthplace Unknown Virginia /
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Jane Gray
15. Birthplace Unknown Virginia /
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Maud Bell
(b) Address Farmington, Missouri
17. (a) Burial Burial **(b) Date thereof** 9-8-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Farmington, Missouri

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) SEP 2 1946 **(b)** [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois 94
 (c) City or town Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. Farmington, Route 4 NR 0
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No) 1
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 5
 year 1946 hour 4 minute 55 P.M.
21. I hereby certify that I attended the deceased from August
4, 1946 to Sept. 5, 1946;
 that I last saw him alive on Sept. 5, 1946;
 and that death occurred on the date and hour stated above.

Immediate cause of death.....
Cardiac Failure
 Due to Hypertensive & Arteriosclerotic Heart disease 8 years
 Due to.....
 Other conditions.....
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings:
 Of operations.....
 Of autopsy Enlargement of heart
 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 David R. Oliver (M. D. or _____) M.O.
 Address Barnes Hospital Date signed 9-5-46

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

MOTHER FATHER

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..... *Edna R. Radwell*
Licensed Embalmer No..... *4077*
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.