

No. 2
-12-45
5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 24 1947
Registration District No. **318**

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6006**
Registrar's No. **1570**

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 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 days** (Specify whether years, months or days)

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

4. Sex **Male 2** 5. Color or race **Col**
6. (a) Single, widowed, married, divorced **Wid. 2**
6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **Oct. 5 1882**
(Month) (Day) (Year)

8. AGE: Years **64** Months **3** Days **2** If less than one day hr. min.

9. Birthplace **Tenn.** (City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business.....

MOTHER FATHER

12. Name **G. Bell**

13. Birthplace **Tenn.** (City, town, or county) (State or foreign country)

14. Maiden name **Eliza ??**

15. Birthplace **Tenn.** (City, town, or county) (State or foreign country)

16. (a) Informant **LESSIE King**
(b) Address **45 26 PAGE AVE**

17. (a) **Shipped** (b) Date thereof **FEB 16 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director **D. S. GRIFFIN**

(b) Address **2915 FRANKLIN**

19. (a) **FEB 15 1947** (b) **J. F. Bredek**
(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. **4526 Page Blvd** (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **13**
year **1947** hour **1** minute **10 P** M.

21. I hereby certify that I attended the deceased from **2-9**, 19**47**, to **2-13**, 19**47**;
that I last saw him alive on **Feb. 13**, 19**47**;
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Psychosis with Organic Brain Disease Undet.
PXXXX

Due to.....
Due to.....

Other conditions **None**
(Include pregnancy within 3 months of death)

Major findings:.....
Of operations.....

Of autopsy **No**

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 **H. J. Ewin** (M. D. or other).....
Address **2601 N Whittier St** Date signed **2/15/47**

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

J. A. Green

Licensed Embalmer No.

2963

P. O. Address

2915 Franklin

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.