

No. 2
2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13858

State File No. _____

FILED MAY 7 1948 318

Primary Registration District No. 1003

Registrar's No. 4079

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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 hrs. 5 mins
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3124 Laclede 9
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Robert John 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 0

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

7. Birth date of deceased: 4 (Month) 10 (Day) 48 (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 2 hr. 5 min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Robert John Bell

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

14. Maiden name Mable McKinney

15. Birthplace _____ Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Eather M. Sherard, RR 2
(b) Address 2601 N. Whittier

17. (a) Anatomical Board (b) Date thereof APR 30 1948
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Rowland Mortuary Service

(b) Address 4104 Manchester Ave

19. (a) APR 15 1948 (b) J. F. Bredack
(Date of filing local register) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 10
year 1948 hour 3 minute 15 M.

21. I hereby certify that I attended the deceased from 1:10 A.M.
4-10- 1948 to 3:15 A.M. 1948
that I last saw him alive on 3-10- 1948
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Atelectasis Neonatorum
Asphyxia Neonatorum

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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 J. F. Bredack (M. D. or other) 4-14-48
Address 2601 N. Whittier (Date signed)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

FATHER {
MOTHER {

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.