

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 23 1953

318

1003

State File No.

37448

Registrar's No.

9881

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. Louis		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. Louis		2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hosp.				d. STREET ADDRESS (If rural, give location) 11 2425 COLEMAN ST.			
3. NAME OF DECEASED (Type or Print) Belle		a. (First)		b. (Middle)		c. (Last) MOSS	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH 1-15-1890	
9. AGE (In years last birthday) 63		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Mill Springs Mo	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME James Gibbs		13b. MOTHER'S MAIDEN NAME Ella Waller		14. NAME OF HUSBAND OR WIFE Fred	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Fred Moss			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Shock following operation ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Adrenal cortical hypofunction years DUE TO (c) Cholecystitis, chronic years II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Rheumatoid arthritis, multiple years				INTERVAL BETWEEN ONSET AND DEATH 1 day	
19a. DATE OF OPERATION 10-13-50		19b. MAJOR FINDINGS OF OPERATION 1. Cholecystitis, chronic 2. Ventral Hernia				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED WHOLE AT WORK <input type="checkbox"/> NOT WHOLE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR 585X					
22. I hereby certify that I attended the deceased from Oct 9, 1953, to Oct 15, 1953, that I last saw the deceased alive on Oct 14, 1953, and that death occurred at 2:30 p.m., from the causes and on the date stated above.							
23a. SIGNATURE Jesse Younger M.D.				23b. ADDRESS 634 N. Grand		23c. DATE SIGNED 10-16-53	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 10-17-53		24c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK		24d. LOCATION (City, town, or county) (State) ST. Louis Co Mo	
DATE RECD BY LOCAL REG. OCT 16 1953		REGISTRAR'S SIGNATURE Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE A. Know Hill 2707 N. Grand			

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Ronald O. Yahink
2917

Licensed Embalmer No. _____

P. O. Address _____

St Louis

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.