

STANDARD CERTIFICATE OF DEATH

40182

State File No. _____

FILED DEC 10 1953

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 11475

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital		e. STREET ADDRESS (If rural, give location) 1601 Square Drive	

3. NAME OF DECEASED (Type or Print)	a. (First) Edward	b. (Middle)	c. (Last) Bell	4. DATE OF DEATH (Month) (Day) (Year) December 1, 1953
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY ?	11. BIRTHPLACE (City and State or Foreign Country) Unknown	12. CITIZEN OF WHAT COUNTRY? U.S.A.			

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Unknown
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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.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Josephine Bell 1601 Square Drive
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH several yrs.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Leucic aneurysm of aorta	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	DUE TO (b) _____		
	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 022X
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22. I hereby certify that I attended the deceased from 11/27, 1953, to 12/1, 1953, that I last saw the deceased alive on 12/1, 1953, and that death occurred at 1:50a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) F. Prudeney M. D.	23b. ADDRESS 600 South Kingshighway	23c. DATE SIGNED 12/2/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 12-5-53	24c. NAME OF CEMETERY OR CREMATORY Green Wood Cem.	24d. LOCATION (City, town, or county) (State) St. Louis County MO
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DATE REC'D BY LOCAL REG. DEC 4 1953	REGISTRAR'S SIGNATURE J. C. Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sneed Funeral Chapel 365 East
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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.....
Signature of Student Embalmer

Signed... *Leroy H. Gannister*

Licensed Embalmer No. *452*

P. O. Address *3880 E...*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.