

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5908

State File No.

FILED MAR 4 1954

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 1049

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) Life		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		e. STREET ADDRESS (If rural, give location) 18 3023 Rutger		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) Dorothy		b. (Middle) Mae		c. (Last) Belle	
4. DATE OF DEATH (Month) (Day) (Year) Jan. 31 1954		5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Sept. 29, 1904		9. AGE (In years last birthday) 49yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY same		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME Donnie Reed		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Robert J. Bell, Sr.		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 Robert J. Bell, 3023 Rutger		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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Glomerulonephritis ANTECEDENT CAUSES Undetermined DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Hypertensive Cardiovascular Disease	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 592x	
22. I hereby certify that I attended the deceased from 1-23, 1954, to 1-31, 1954, that I last saw the deceased alive on 1-31, 1954, and that death occurred at 3:05 p. m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <i>Edward B. Williams</i>		23b. ADDRESS 2601 N Whittier ST		23c. DATE SIGNED 2-1-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2/ 5/ 54		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		DATE REC'D BY LOCAL REG. FEB 2 1954		REGISTRAR'S SIGNATURE <i>Charles J. Gates</i>	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Charles J. Gates, 4107 Finney Ave.			

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 *Arthur L. Hellard*.....

Licensed Embalmer No. 4221

P. O. Address 4107 Fin

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.