

FILED SEP 6 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **28121**  
Registrar's No. **6957**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>6957</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Louis</b>		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 <b>Homer G. Phillips Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>222 9/2 2347 Hickory</b>			
3. NAME OF DECEASED a. (First) <b>Ella</b> (Type or Print)			b. (Middle) _____			c. (Last) <b>Betts</b>	
4. DATE OF DEATH (Month) (Day) (Year) <b>7 25 56</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	
8. DATE OF BIRTH <b>Unknown</b>		9. AGE (In years last birthday) <b>abt 78</b>		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) <b>Miss</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>Miss</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Unknown</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Hospital Records</b> ADDRESS <b>2601 7/2</b>			
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, asphemia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardiovascular Accident, Thrombosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>			
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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. <b>Bronchopneumonia</b> <b>Hypertensive Cardiovascular Disease</b>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? <b>4201</b> YES <input checked="" type="checkbox"/> NO <input 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 WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <b>7-15</b> , 19 <b>56</b> , to <b>7-25</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>7-25</b> , 19 <b>56</b> , and that death occurred at <b>1:05a</b> m., from the causes and on the date stated above.							
23a. SIGNATURE <b>Hugh Waters</b> (Degree or title) <b>M.D.</b>				23b. ADDRESS <b>2601 N. Whittier St.</b>		23c. DATE SIGNED <b>7-26-56</b>	
24a. BURIAL/CREMA-TION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>July 30/56</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Oak Dale Cem</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., MO</b>	
DATE REC'D BY LOCAL REG. <b>JUL 27 1956</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>F. A. Green</b> ADDRESS <b>4214 Delmar</b>			

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

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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..... *F. A. Green* .....

Licensed Embalmer No. *2963*

P. O. Address *4214 Delmar*

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.