

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

45601 STATE FILE NUMBER 12082 REGISTRAR'S NO.

FILED DEC 30 1957

Registration District No. 318 Primary Registration District No. 1003

V. S. 300 Rev. 1-57

1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hospital Length of stay in 1b 22 HOSPITAL OR INSTITUTION St. Anthony Hospital d. STREET ADDRESS 5621 Walsh St. 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY Mo. c. CITY OR TOWN St. Louis Inside Limits Yes No Inside Limits Yes No Reside on Form Yes No 3. NAME OF DECEASED (Type or print) First Middle Last BERNICE M. BEDWELL 4. DATE OF DEATH Month Day Year Dec. 14 1957 5. SEX Female 6. COLOR OR RACE White 7. MARRIED NEVER MARRIED WIDOWED DIVORCED 8. DATE OF BIRTH July 31, 1920 9. AGE (In years last birthday) 37 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Claim Adjustor-Automobile Club of Mo. 11. BIRTHPLACE (City and state or country) St. Louis, Mo. 12. CITIZEN OF WHAT COUNTRY? U.S.A. 13a. FATHER'S NAME William Ficker 13b. MOTHER'S MAIDEN NAME Sophie Eckert 14. NAME OF HUSBAND OR WIFE John S. Bedwell 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No None 16. SOCIAL SECURITY NO. 17. INFORMANT Address John S. Bedwell 5621 Walsh St. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ac dilatation of heart DUE TO (b) Diabetes Mellitus DUE TO (c) Generalized metastases of Ca from abdomen PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 260xH 19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. 20d. INJURY OCCURRED WHILE AT NOT WHILE WORK AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 20f. CITY, TOWN, OR LOCATION COUNTY STATE 21. I attended the deceased from 2-1-57 to 12-14-57 and last saw her alive on 12-14-57 Death occurred at 8:40 P. m on the date stated above; and to the best of my knowledge, from the causes stated. 22a. SIGNATURE (Degree or title) Bruce D. Creelies M.D. 22b. ADDRESS 752 Lemay Ferry Rd. 22c. DATE SIGNED 12-16-57 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE Dec. 18, 1957 23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park 23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo. 24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway 25. DATE RECD. BY LOCAL REG. DEC 16 57 26. REGISTRAR'S SIGNATURE J. Carl Smith MD mfs

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION

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 *William B. White* .....

Licensed Embalmer No. *4291* .....

P. O. Address *448 Stange St* .....

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.