

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-043956

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

FILED DEC 14 1962

1003

11795

318

VS 300  
Rev. 4/59

1  
2 210  
3  
4 2  
5 2  
6  
7 0  
8 -2  
9  
10  
11  
12 90-0  
13

STATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS:

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4512 ASHLAND AVE</b>		d. STREET ADDRESS (If outside, give location) <b>4512 ASHLAND AVE</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RAYMOND BELL</b>			4. DATE OF DEATH <b>12-6-1962</b>
First Middle Last			Month Day Year
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>colored</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-25-14</b>
9. AGE (last birthday) <b>48 YRS</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AMERICAN STEEL</b>	11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>		13a. FATHER'S NAME <b>GARFIELD BELL</b>	
13b. MOTHER'S MAIDEN NAME <b>MAC WILLIAMS</b>		14. NAME OF HUSBAND OR WIFE <b>LESTER BELL 4636 MARGARETTA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>4636 MARGARETTA</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary Artery Disease</b>		DUE TO (c) <b>4207</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	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 WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
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 <b>12-5-62</b> to <b>12-6-62</b> and last saw her/him alive on <b>12-4-62</b> . Death occurred at <b>12-6-62 10:00 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Alan Moore M.D.</b>		22b. ADDRESS <b>2814 N Taylor</b>	22c. DATE SIGNED <b>12-7-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>12-11-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON PARK</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS CTY MO</b>
24. FUNERAL DIRECTOR ADDRESS <b>A.F. WALTON 2707 STANDARD ST.</b>		25. DATE REC'D. BY LOCAL REG. <b>DEC 10 1962</b>	26. REGISTRAR'S SIGNATURE <b>Alan Smith, M.D.</b>

FILED DEC 14 1964

**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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 1123 H. Taylor

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.