

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

17165

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St Louis Mo** (No. **Barnes Hospital**)

File No.

Registered No. **5157**

St. Ward)

2. FULL NAME

Charles Rufus Bell

(a) Residence. No. **2824 a Gamble** St. **21** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Addie Bell

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Jan. 3 - 1887

7. AGE

YEARS **45**

MONTHS **4**

DAYS **27**

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Minister 131 1326

(b) General nature of industry, business, or establishment in which employed (or employer)

102

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Miss

PARENTS

10. NAME OF FATHER

Feelin Bell.

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss.

12. MAIDEN NAME OF MOTHER

Wora Thomson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss

14.

INFORMANT

(Address)

Addie Bell

2824a Gamble St

15.

FILED

NO. 3

Mar. 6 Staroboff

REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-31 1927

17.

I HEREBY CERTIFY, That I attended deceased from **5-26**, 19**27**, to **5-31**, 19**27**, that I last saw him alive on **5-31**, 19**27**, and that death occurred, on the date stated above, at **2:20 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

**uremia
nephritis - chronic
hypertension**

(duration) **?** yrs. mos. da.

CONTRIBUTORY (SECONDARY)

1290

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? **no** DATE OF

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **Robert M Evans**, M. D.

, 19 (Address) **Barnes Hospital**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Cape Girardeau Mo June 3 1927

20. UNDERTAKER

A. L. Bial

ADDRESS **2726**

Lucas Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1850

1851

1852

1853

+

1854

1855

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1861

1862