

1939 JUL 12 1939

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

20236
Do not use this space.

1. PLACE OF DEATH

(a) County.....² Registration District No.....**791**
(b) Township..... Primary Registration District No.....**1008**
(c) City.....**St. Louis Mo.** (d) Street No.....**4126 Shenandoah** St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No.....**5080**

2. PRINT FULL NAME **William Lee Bess.**

(a) Residence, No..... St. **NR** **Crocker Mo.**
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED **Married**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Sept. 14th, 1882**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	56	8	20	

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Farmer**

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **June 3, 1939**

22. I HEREBY CERTIFY, That I attended deceased from **May 23, 1939 to June 3, 1939**

I last saw him alive on **June 3, 1939** Death is said to have occurred on the date stated above, at **6:35 P.M.**

The principal cause of death and related causes of importance were as follows:
Aspirin with generalized metastases of primary cancer undetermined.

Other contributory causes of importance:
Hemiplegia

Name of operation **None** Date of.....

What test confirmed diagnosis? **Biopsy** Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **No.**
If so, specify **Gen. C. Bess**, M. D.
(Signed) **Gen. C. Bess**
(Address) **3615 So. Grand**

Date of onset **6-28-39**

12. BIRTHPLACE (CITY OR TOWN) **Fredericktown Mo.**
(STATE OR COUNTRY)

FATHER 13. NAME **Christopher Bess.**

14. BIRTHPLACE (CITY OR TOWN) **North Carolina.**
(STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME **Amanda Clubb**

16. BIRTHPLACE (CITY OR TOWN) **North Carolina.**
(STATE OR COUNTRY)

17. INFORMANT **Mrs. Martha Bess.**
(ADDRESS) **Crocker Mo.**

18. BURIAL, CREMATION, OR REMOVAL **June**
PLACE **Farmington Mo** DATE **6th, 1939.**

19. FUNERAL DIRECTOR (NAME) **Albert H. Hoppe**
(ADDRESS) **4700 Washington Ave**

20. FILED **JUN 5 1939**
Local Registrar.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

FORM 1 X 16403

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

J. G. Sullivan

Licensed Embalmer No. 1122

P. O. Address.....

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 this body is not embalmed, above space should be left blank.