DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 20834

Registration District No. 791 1003 — Primary Registration District No. — Registrar's No. 5678

REC'D JUL 12 1939

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 5130 Ashland Ave. 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 1 L

(d) Street No. 5130 Ashland Ave. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Belle T. Fortier

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 8th (Month) 4th. (Day) 1879 (Year)

8. AGE: Years 59 Months 10 Days 23 If less than one day hr. min.

9. Birthplace Mo. (City, town, or county) (State or foreign country)

10. Usual occupation None 0

11. Industry or business 0

FATHER
12. Name Paul Fortier 0
13. Birthplace Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Unknown.
15. Birthplace Mo. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Leslie L. Fortier
(b) Address Leslie 5130 Ashland.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 30 39 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Cem.

18. (a) Signature of funeral director Drehmanne Harrel
(b) Address 1905 Union Blvd.

19. (a) (Date received local registrar) JUN 28 1939 (b) J D Bridgeh (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27 year 1939 hour 9 minute 10 a M.

21. I hereby certify that I attended the deceased from June 22, 1939, to June 27, 1939; that I last saw her alive on June 26, 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Myocarditis	1 Year
Due to	
Due to	
Other conditions: Paralysis lower extremities (Include pregnancy within 3 months of death)	3 Y.

Major findings: Of operations Removed of Tubular Spine, Cervical 3 years

Of autopsy None

PHYSICIAN: Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Geo B Krueger (M. D. ~~or other~~)
Address 3442 Geraldine Date signed 6/27/39

(Licensed Embalmer's Statement on Reverse Side)

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.

WHITE PAINTY USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

I X19511

Geraldine & Valen

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 R. M. Sanford

Licensed Embalmer No. 2273

P. O. Address St Louis

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.