

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37760

Registration District No. 791
1000

Primary Registration District No. _____

Registrar's No. 9599

1. PLACE OF DEATH:

(a) County 1
(b) City or town St. Louis
(c) Name of hospital or institution: Homer G. Phillips
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 days
(Specify whether _____)
In this community Unknown
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4235 N. Market (West)
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME

Kitty Bellamy 4500

3. (b) If veteran, name war ***

3. (c) Social Security No. *****

4. Sex Female

5. Color or race Negro

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

6. (b) Name of husband or wife William Bellamy

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased December 23rd 1887
(Month) (Day) (Year)

8. AGE: Years 51 Months 10 Days 15
If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Archer Dobson

13. Birthplace Smithland Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Sallie

15. Birthplace Smithland Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mary Anderson

(b) Address 4325 West N. Market St.

17. (a) Removal (b) Date thereof 11-10-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Smithland, Kentucky

18. (a) Signature of funeral director Chas. Gates

(b) Address 4107 Finney Ave.

19. (a) NOV 10 1939 (b) J. E. Bradish
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 8
year 1939 hour 5:10 minute A. M.

21. I hereby certify that I attended the deceased from 10-25-, 1939, to 11-8-, 1939;
that I last saw h. er alive on 11-8-, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease
About 4 yrs.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration

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? _____

While at work? _____ (Specify typical place) (e) Means of injury _____

23. Signature Henry S. Campbell (Date signed) _____

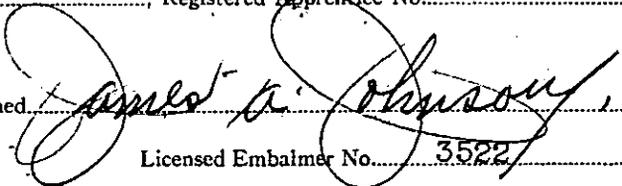
Address 2601 N. Whittier St. Date signed 11-10-39

USE BY 11/1/76

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.....
.....James A. Johnson....., Registered Apprentice No.....
working under my personal supervision.

Signed.....



Licensed Embalmer No.....3522.....

P. O. Address 4107 Finney Ave......

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.