

JAN 15 1941

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution: Central Hospital
(d) Length of stay: In hospital or institution Hospital
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(d) Street No. Woodbine Hotel
(e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME Daniel Arthur Bell

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Katie Bell 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased Feb. 26, 1858
(Month) (Day) (Year)

8. AGE: Years 82 Months 9 Days 5 If less than one day hr. _____ min. _____

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

10. Usual occupation Shoe repairs

11. Industry or business _____

12. Name William Bell

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

14. Maiden name Martha Angel

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

16. (a) Informant's own signature Wm L Bell
(b) Address 4530 Washington Bl.

17. (a) Cremation (b) Date thereof 12/4/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Charles H. ...
(b) Address 4911 Washington Bl.

19. (a) DEC 3 1940 (b) J. H. Buech
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 1
year 1940 hour 11 minute 00 M.

21. I hereby certify that I attended the deceased from Nov 29 to Dec 1, 1940
that I last saw him alive on Dec 1, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary occlusion
occlusion 4 days

Due to Atherosclerosis

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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 type of place) (e) Means of injury _____

23. Signature J. H. Buech (M. D. or other) _____
Address 4530 Washington Date signed 12/1/40

WHITE PENCIL—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.

1 X1931

12/2-40

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

Thomas R. Fenwick

Licensed Embalmer No. *3793*

P. O. Address *St. Louis, Mo*

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.