No. 2
1-13-40
-17-39
X23159

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 40848

Registration District No. 7911 | Primary Registration District No. | Registrar's No. 10619

1. PLACE OF DEATH:
(a) County: City of St. Louis
(b) City or town: St. Louis, Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1035 Childress Ave. St. Louis, Mo. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 (Specify whether years, months or days)
In this community:

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: St. Louis
(c) City or town: St. Louis 4 (If outside city or town limits, write "RURAL")
(d) Street No. 1035 Childress Ave. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: Kenneth G. Bellairs
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: M
6. (b) Name of husband or wife: Ollie Evans Bellairs
6. (c) Age of husband or wife if alive: 70 years
7. Birth date of deceased: 4 (Month) 17 (Day) 1869 (Year)

8. AGE: Years	Months	Days	If less than one day
71	8	7	hr. min.

9. Birthplace: Calcutta (City, town, or county) India (State or foreign country) 7
10. Usual occupation: Reporter 4
11. Industry or business: Star-Times Newspaper 7
FATHER
12. Name: Clement W. Bellairs
13. Birthplace: Unknown (City, town, or county) England (State or foreign country)
MOTHER
14. Maiden name: Mary Agabag
15. Birthplace: Unknown (City, town, or county) France (State or foreign country)
16. (a) Informant: Ollie Evans Bellairs
(b) Address: 1035 Childress, St. Louis
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12 (Month) 26 (Day) 40 (Year)
(c) Place: burial or cremation: Memorial Park
18. (a) Signature of funeral director: [illegible]
(b) Address: 6633 Clayton Rd.
19. (a) DEC 25 1940 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 24 year 1940 hour 3 minute 40 A.M.
21. I hereby certify that I attended the deceased from Dec. 18, 19 40 to December 24, 19 40 that I last saw him alive on December 24, 19 40 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Lobar pneumonia	5 days
Due to Toxemia	6 mo
Due to Chr inflammation of gall bladder w/ stones	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: None
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: Leon Decker (M. D. or Other)
Address: 3547 Utah Plc. Date signed 12/24/40

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 1994

P. O. Address Clayton Ala.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.