

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____
 Registrar's No. **10636**

FILED DEC 22 1943
 Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
 (a) County _____
 (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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **12 days**
 In this community **10 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **000 17**
 (c) City or town **St. Louis, Mo.** **125**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1730 O'Fallon**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____ **0**

3. (a) PRINT FULL NAME **Isabel Bellfountainne**
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex **Female** **5. Color or race** **Cauc** **6. (a) Single, widowed, married, divorced** **wid**
6. (b) Name of husband or wife **Herry Hamilton** **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased **Unknown**
(Month) (Day) (Year)

8. AGE: Years **abt. 88** Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) **Tenn**

10. Usual occupation **Unemployed**

11. Industry or business _____
MOTHER { **12. Name** **Unknown**
13. Birthplace _____ (City, town, or county) (State or foreign country) **Tenn**
14. Maiden name **Unknown**
15. Birthplace _____ (City, town, or county) (State or foreign country) **Tenn**

16. (a) Informant **Stathie Tate**
(b) Address **Memphis Tenn**

17. (a) Burial, cremation, or removal **Greenwood** **(b) Date thereof** **12-6-43**
(Month) (Day) (Year)

18. (a) Signature of funeral director **J. H. Harrison**
(b) Address **2906 Patton**

19. (a) DEC 3 1943 (Date received local registrar) **(b) J. F. Bredbeck** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **1,** year **1943** hour **7** minute **10 P. M.**
21. I hereby certify that I attended the deceased from **November 19,** 19**43** to **December 1,** 19**43;**
 that I last saw her alive on **December 1,** 19**43;**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Arteriosclerotic Gangrene of right foot.** **Duration** **3 mos**

Due to _____
 Due to _____
 Other conditions **9/12**
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: **Of operations** _____
Of autopsy _____
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? _____

23. Signature **G. M. Jackson** (M. D. or other)
Address **260 Whitehall** **Date signed** **12/1/43**
While at work? _____ (Specify type of place) (e) Means of injury _____

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..... *Arthur P. Hilliard*

Licensed Embalmer No. *42351*

P. O. Address *4219 E Gayfield*

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, fact should be so stated above.