

FILED SEP 13 1945

1003

7723

Registration District No.

Primary Registration District No.

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: City Infirmery 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 months 13 days
(Specify whether
In this community 20 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 060
(c) City or town St. Louis. 17 21
(If outside city or town limits, write "RURAL")
(d) Street No. 5800 Arsenal St. 2712 Cole Ave.
(If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ROBERT BELL

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

4. Sex Male 2 5. Color or race Colored 6. (a) Single, widowed, married, divorced Separated
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 2 15 1871
(Month) (Day) (Year)

8. AGE: Years 74 Months 6 Days 16 If less than one day _____ hr. _____ min.

9. Birthplace Starksville Miss. /
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

12. Name Ben Bell
13. Birthplace _____ Miss. /
(City, town, or county) (State or foreign country)
14. Maiden name Isabel
15. Birthplace _____ Miss. /
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. Windsheimer

(b) Address 5800 Arsenal St.

17. (a) Rural (b) Date thereof 9-5-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director J. Ryan

(b) Address 5800 Arsenal

19. (a) SEP 4 1945 (b) J. F. Brudick
(Date certified legal death) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September 1st;
year 1945 hour 2:00 A.M. minute _____ M.

21. I hereby certify that I attended the deceased from July
the 2nd; 19 45 to September 1, 19 45
that I last saw him alive on September 1, 19 45;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Hypertensive Heart Disease 1944 pl.
Due to Generalized Arteriosclerosis 1944 "

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? _____

(Specify type of place)
While at work? _____ (c) Means of injury _____
23. Signature Dalmon Primm Bowlin (M. D. or other) _____
Address 5800 Arsenal Date signed 9/2/45

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

MOTHER FATHER

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.....

P. O. Address.....

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.