

3. No. 2
-12-45
5-17-39
PI X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11890
Registrar's No. 569

FILED APR 14 1947
Registration District No. 3

Primary Registration District No. 6076

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

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Sappington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
R.R.#6 Box 345
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Viola Bissell
3. (b) If veteran, name war.....
3. (c) Social Security No. None

4. Sex Female 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Albert Bissell
6. (c) Age of husband or wife if alive 38 years
7. Birth date of deceased Dec 12 1914
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
32 2 23 hr. min.

9. Birthplace: Pa. Mo. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER
12. Name Thomas Bartch
13. Birthplace Pa. 1
(City, town, or county) (State or foreign country)
14. Maiden name Minnie Babb
15. Birthplace Ark. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Albert Bissell
(b) Address R.R.6 Box 345 Sappington

17. (a) Burial (b) Date thereof 3-4-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St Pauls Churchyard

18. (a) Signature of funeral director Louis H. Bonn, Inc.
(b) Address Kirkwood, Mo.

19. (a) 3-14-47 (b) Ruth Gallen MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St Louis
(c) City or town Sappington
(If outside city or town limits, write "RURAL")
(d) Street No. R.R.#6 Box 345
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 6
year 1947 hour 7 minute 30 P M.

21. I hereby certify that I attended the deceased from Aug 6 1946 to March 6 1947
that I last saw him ER alive on Feb 27 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Ruptured aortic aneurysm ?
Duration

Due to 30d.

Other conditions Pregnancy
(Include pregnancy within 3 months of death) 8 1/2 mo.

Major findings:
Of operations.....

Of autops Ruptured aortic aneurysm
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) (b) Means of injury

23. Signature Joan M. Jones M. D. or other
Address 508 N. Kirkwood Rd Date signed 4/1/47

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 Peter B. Dubroville

Licensed Embalmer No. 3691

P. O. Address Richmond Heights

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.