1/47
17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

STANDARD CERTIFICATE OF DEATH

State File No. 11015

FILED APR 5 1948

Registration District No. 379 — Primary Registration District No. 6076 — Registrar's No. 616

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

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: 000
(c) City or town: St. Louis (If outside city or town limits, write "RURAL") 17
(d) Street No.: 5929 Wells Ave., (If rural, give location) 9
(e) Citizen of foreign country? ..... (Yes or No) 1
If yes, name country .....

3. (a) PRINT FULL NAME: Adelia Betts.
3. (b) If veteran, name war: No
3. (c) Social Security No.: None

4. Sex: Female 1
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed 2
6. (b) Name of husband or wife: George I. Betts
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: July 5, 1864. (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
83	7	27	hr. ..... min.

9. Birthplace: St. Louis, Mo. 0 (City, town, or county) (State or foreign country)
10. Usual occupation: Retired
11. Industry or business .....
12. Name (Father): Theordia Anslyn
13. Birthplace (Father): Australia 8 (City, town, or county) (State or foreign country)
14. Maiden name (Mother): Unknown
15. Birthplace (Mother): Unknown 9 (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs. Ethel Slinkard
(b) Address: 5929 Wells Ave.,
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 8/48 (Month) (Day) (Year)
(c) Place: burial or cremation: Bellefountain Cem.
18. (a) Signature of funeral director: Jos. W. Clark
(b) Address: 1125 Hodiamont Ave.,
19. (a) 3-6-48 (Date received local registrar) (b) Cecila Stapp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Mar. day: 3 year: 1948 hour: 1.30 minute: P.M. M.
21. I hereby certify that I attended the deceased from Jan 1, 1948, to Mar 1, 1948, that I last saw her alive on Mar 1, 1948, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Arteriosclerosis Heart disease	yrs.
Due to: Gen. arteriosclerosis	yrs.
Due to:	
Other conditions: Fracture of R femur (Include pregnancy within 3 months of death)	1 wk.

Major findings:
Of operations: 1860
Of autopsy: no

PHYSICIAN — Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): fall
(b) Date of occurrence: 2-20-1948
(c) Where did injury occur? Home (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: fall
23. Signature: Lawrence M. Klaus (M. D. or other)
Address: 608 N. Grand Date signed: Mar. 1/49

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

Dr. Lawrence M. Kotner,
508 No. Grand Blvd.,
NE. 8593, 1-4 P.M.

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 Tony Bonn, Registered Apprentice No. 102, working under my personal supervision.

Signed Alfred F. Boedeker

Licensed Embalmer No. 2663

P. O. Address 1125 Hodiamont Ave.,

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.

No. 2B
4-25-41
PI X27852

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 0

Registration District No. 317 Primary Registration District No. 6876 Registrar's No. 666

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

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Bellerive (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Pure Crest Nursing Home (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days) In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County .....

(c) City or town St Louis (If outside city or town limits, write "RURAL")

(d) Street No. ..... (If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Betts, Adelia

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased 7-5-64 (Month) (Day) (Year)

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

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

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER

12. Name .....

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

14. Maiden name .....

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

16. (a) Informant .....

(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)

(c) Place: burial or cremation .....

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

(b) Address .....

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day ..... year ..... hour ..... minute ..... M.

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

Immediate cause of death ..... Duration

Due to Gen. Arteriosclerosis

Due to Fractured humerus

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) Death not due to accident

(b) Date of occurrence Feb 20, 1948

(c) Where did injury occur? Home. St. L. Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home. (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature L. M. Stern (M. D. or other)

Address 5084 Chaud Date signed Mar 6

SUPPLEMENTARY

S-11015