

FILED OCT 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34581

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8363**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Mississippi	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) Charleston	
c. LENGTH OF STAY (in this place) 1 day		d. STREET ADDRESS (If rural, give location) 512 S. Locust St. /	
d. FULL NAME OF HOSPITAL OR INSTITUTION H. G. Phillips Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) _____ c. (Last) Bell			4. DATE OF DEATH (Month) (Day) (Year) Sept. 25, 1950		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct. 23, 1894	9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Months 11 Days 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) Belmont, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Alec Butler		13b. MOTHER'S MAIDEN NAME Lena Bullocks		14. NAME OF HUSBAND OR WIFE Dame Bell, deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Mrs. Zenobia Thomas, 512 S. Locust, Charleston, Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Apoplexy		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Hypertension		2 weeks	
		DUE TO (b) _____			
		DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 231X	

22. I hereby certify that I attended the deceased from **9/19, 1950** to **9/25, 1950**, that I last saw the deceased alive on **9/25, 1950**, and that death occurred at **4:00 P. M.**, from the causes and on the date stated above.

23a. SIGNATURE D. J. Payne M.D. (Degree or title)		23b. ADDRESS 3146 E. Waterloo St. St. Louis		23c. DATE SIGNED 9/29/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE Sept. 26, 1950		24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	
				24d. LOCATION (City, town, or county) (State) Charleston, Missouri	

DATE REC'D BY LOCAL HEALTH DEPT. UCL 4 1950		REGISTRAR'S SIGNATURE J. B. Basater		25. FUNERAL DIRECTOR'S SIGNATURE F. J. Sparks ADDRESS Charleston, Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Frank J. Sparks

Licensed Embalmer No. 8455

P. O. Address Cape Girardeau

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.