

FILED JAN 25 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3299**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **2070** Registrar's No. **118**

1. PLACE OF DEATH a. COUNTY ST LOUIS COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY ST LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) Webster Groves, Mo		c. CITY (If outside corporate limits, write RURAL and give township) Webster Groves, Mo	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 703 ELM AVE	
d. FULL NAME OF HOSPITAL OR INSTITUTION 703 ELM AVE			

3. NAME OF DECEASED (Type or Print) a. (First) BARBARA ANN b. (Middle) BELL c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) JAN 12 1951		
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	
8. DATE OF BIRTH November 1, 1934		9. AGE (In years last birthday) 15		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) ST LOUIS MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A		13a. FATHER'S NAME Clifford Bell	
13b. MOTHER'S MAIDEN NAME HELEN HARRIS		14. NAME OF HUSBAND OR WIFE HELEN WEST		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Helen West 703 Elm Ave			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Influenza		INTERVAL BETWEEN ONSET AND DEATH 3 days	
		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Sporadic paralysis		15 years	
		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) 351 X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Jan 7, 1951**, to **Jan 12, 1951**, that I last saw the deceased alive on **Jan 12, 1951**, and that death occurred at **7:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE W. S. Webb M.D.		23b. ADDRESS 114 Wood Mo.		23c. DATE SIGNED 1-15-51	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE January 16-51		24c. NAME OF CEMETERY OR CREMATORY Father Dickson Cemetery Kirkswood Mo		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. 1/15/51		REGISTRAR'S SIGNATURE Herbert R. Donke M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Theodore J. Goodell		ADDRESS 130 Eldridge	

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

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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

.....
working under my personal supervision.

Student Embalmer No.

Signed

Theodore J. Candell

Signed

.....
Student Embalmer

Licensed Embalmer No. *4243*

P. O. Address

*130 Eldridge
Westerly, Rhode Island*

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.