FILED SEP 24 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32880

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8337

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Luke's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2119
d. STREET ADDRESS (If rural, give location): 11 3743 Windsor Place

3. NAME OF DECEASED (Type or Print)
a. (First) BELL, b. (Middle) Mrs. Mary c. (Last)

4. DATE OF DEATH (Month) (Day) (Year): 8 · 25 · 53

5. SEX: F 3
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 2
8. DATE OF BIRTH: 2·14·04
9. AGE (In years last birthday): 89 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country): Mississippi 1
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: Willie Pertut
13b. MOTHER'S MAIDEN NAME: Fannie Pry
14. NAME OF HUSBAND OR WIFE: George

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Mrs Cornelia Pepper — ADDRESS: City 3743 Windsor

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peripheral Vascular Collapse

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Malignant Hypertension
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

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) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR? 445X

22. *I hereby certify that I attended the deceased from* 7/9, 1953, *to* 8-25, 1953, *that I last saw the deceased alive on* 8-25, 1953, *and that death occurred at* 1:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Theodore J. Repp Jr. M.D.
23b. ADDRESS: St. Luke's Hospital
23c. DATE SIGNED: 8-25-53

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24b. DATE: 8-31-53
24c. NAME OF CEMETERY OR CREMATORY: Washington Park
24d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

DATE REC'D BY LOCAL REG.: AUG 27 1953
REGISTRAR'S SIGNATURE: J. Earl Smith, M.D.
25. FUNERAL DIRECTOR'S SIGNATURE: E. B. Koonce Mortuary — ADDRESS: 1 N. Grand

E.P. (Licensed Embalmer's Statement on Reverse Side)

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 Guyton Swan

Licensed Embalmer No. 45-80

P. O. Address 122 N Gran

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.