

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20180

State File No. _____

4545

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN <u>St. Louis;</u> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>1414 East Gano Ave.</u>		e. STREET ADDRESS (If rural, give location) <u>1414 East Gano Ave.</u> <u>2099</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Nellie</u> b. (Middle) <u>Agnes</u> c. (Last) <u>Bell</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 17 1954</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, <input checked="" type="checkbox"/> DIVORCED (Specify)	8. DATE OF BIRTH <u>Jan. 17 1893</u>
10a. USUAL OCCUPATION (Give kind of work: don't describe more of working life, even if retired) <u>Upholsterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>	9. AGE (In years last birthday) <u>61</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME <u>John Price</u>	13b. MOTHER'S MAIDEN NAME <u>Ellen Monahan</u>	14. NAME OF HUSBAND OR WIFE <u>deceased</u>
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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. <u>493-10-0750</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Val C. Bell</u> ADDRESS <u>1414 E. Gano</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Haemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Essential Hypertension +</u> DUE TO (c) <u>Arteriosclerosis</u>		
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"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>381X</u>
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22. I hereby certify that I attended the deceased from March 19 1954, to 5-1-54, 1954, that I last saw the deceased alive on 5/1/54, 1954, and that death occurred at 7 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>John A. Hartung M.D.</u>	23b. ADDRESS <u>2807 W. Grand Blvd.</u>	23c. DATE SIGNED <u>5-20-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>5/21/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>
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DATE REC'D BY LOCAL REG. <u>MAY 21 1954</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Sullivan's 2849 N. Euclid Ave</u>
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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.....
Signature of Student Embalmer

Signed..... *Albert Mayfield*
Licensed Embalmer No. *307*
P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.