

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **35127**  
Registrar's No. **9601**

BIRTH NO. **72556-54** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

<b>1. PLACE OF DEATH</b> a. COUNTY		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b>		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Bethesda Hospital</b>		e. STREET ADDRESS <b>23 2603 St. Vincent</b>		f. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or Print)		a. (First) <b>Clyde</b>		b. (Middle) <b>Larue</b>		c. (Last) <b>Bell</b>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Oct. 22, 1954</b>		
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>Never Married</b>		<b>8. DATE OF BIRTH</b> <b>Oct. 14, 1954</b>		<b>9. AGE</b> (In years last birthday) <b>8</b> # UNDER 1 YEAR Months # UNDER 24 HRS. Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None.</b>			<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>St. Louis, Mo.</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>	

<b>13a. FATHER'S NAME</b> <b>Clyde Bell</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Wanda Blunt</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>None</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Nil.</b>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Clyde Bell, 2603 St. Vincent</b>	

<b>18. CAUSE OF DEATH</b> 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>		<b>MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
		<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Pneumonia</b>		<b>1 day</b>	
		<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>DUED TO (b) Congenital Esophageal Atresia</b>		<b>6 days</b>	
		<b>DUED TO (c)</b>			
		<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death. <b>Herb lip &amp; Cleft Palate</b>		<b>6 days</b>	

<b>19a. DATE OF OPERATION</b> <b>19 Oct 54</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>Congenital Esophageal Atresia - 5-7cm Defect</b>		<b>20. AUTOPSY</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <b>7562</b>	

**22. I hereby certify that I attended the deceased from Oct 18, 1954, to Oct 22, 1954, that I last saw the deceased alive on Oct 21, 1954, and that death occurred at 1:15a m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> <i>[Signature]</i>		<b>23b. ADDRESS</b> <b>634 N. Grand St. Louis 3</b>		<b>23c. DATE SIGNED</b> <b>Oct 22, 54</b>	
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>		<b>24b. DATE</b> <b>10-22-54</b>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>New Hope Cemetery</b>	
		<b>24d. LOCATION</b> (City, town, or county) (State) <b>Salem, Mo.</b>			

<b>DATE REC'D BY LOCAL REG.</b> <b>OCT 22 1954</b>		<b>REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Albert H. Hoppe, 4700 Washington Blvd.</b>	
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(Licensed Embalmer's Statement on Reverse Side)

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

0.300  
0.48

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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 ..... Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *J. W. Wilkinson*

Licensed Embalmer No. *35*

P. O. Address *M. L. L...*

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.