

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13385**
3136

FILED APR 18 1955

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 institution). a. STATE Illinois b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN E. St. Louis	
c. LENGTH OF STAY (in this place) 1 day		d. STREET ADDRESS (If rural, give location) 1225 Walnut Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Inf.			

3. NAME OF DECEASED (Type or Print) a. (First) Ben b. (Middle) B. c. (Last) Hall			4. DATE OF DEATH (Month) (Day) (Year) 4 3 1955		
5. SEX M		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH 2/28/1876		9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Barber		11. BIRTHPLACE (State or foreign country) Texarkana, Ark.	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	

17. INFORMANT'S SIGNATURE OR NAME Henry Patten		ADDRESS 1717 Tudor	
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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, athermia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) STRANGULATED INGUINAL HERNIA		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) _____ DUE TO (c) _____			

19a. DATE OF OPERATION 4/3/55		19b. MAJOR FINDINGS OF OPERATION GANGRENE of THE INTESTINE		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? 5613	

22. I hereby certify that I attended the deceased from **4/2**, 19**55**, to **4/3**, 19**55**, that I last saw the deceased alive on **4/2**, 19**55**, and that death occurred at **7:45** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Frank C. Lindenberg MD		23b. ADDRESS 928 N. 2ND ST.		23c. DATE SIGNED 4/6/55	
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24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 4/18/55		24c. NAME OF CEMETERY OR CREMATORY Booker Washington	
				24d. LOCATION (City, town, or county) (State) E. St. Louis, Ill.	

DATE REC'D BY LOCAL REG. APR 7 1955		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE R. M. G. Green	
				ADDRESS 44060 Green Washington	

(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 Edgar A. Green

Licensed Embalmer No. 4521

P. O. Address 4060 Washington

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.