

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38007
State File No.
Registrar's No. 9951

FILED NOV 18 1955

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____	
1. PLACE OF DEATH a. COUNTY <u>Missouri</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</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) <u>21y 11m 19d</u>	c. CITY OR TOWN <u>St. Louis</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Chronic Hospital</u>			e. STREET ADDRESS (If rural, give location) <u>13 5600 Arsenal</u>		
3. NAME OF DECEASED (Type or Print) <u>Martha</u>		a. (First)	b. (Middle)	c. (Last) <u>Bell</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>11 15 1955</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>? ? 1885</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months Days IF UNDER 1 HR. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>?</u>		13b. MOTHER'S MAIDEN NAME <u>?</u>		14. NAME OF HUSBAND OR WIFE <u>Macomb Bell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Chronic Hospital, 5600 Arsenal</u>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Vascular Accident</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Negres tenaise Cardiovascular Disease</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u> <u>years</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>443x</u>				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) (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 <u>11/26</u> , <u>1954</u> , to <u>11/15</u> , <u>1955</u> , that I last saw the deceased alive on <u>11/15</u> , <u>1955</u> , and that death occurred at <u>12:40AM</u> from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>George M. Tanaka, M.D.</u>		23b. ADDRESS <u>5600 Arsenal</u>		23c. DATE SIGNED <u>Nov. 15, 1955</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>11-22-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, MO</u>		
DATE REC'D BY LOCAL REG. <u>NOV 15 1955</u>	REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. H. Beal 4303 Delmar</u>		

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, *Samuel W. Deffen*.....

Licensed Embalmer No. *480*.....

P. O. Address *4415 May*.....

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.