

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7655

State File No.

FILED MAR 5 1956

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>500</u>		Registrar's No. <u>342</u>	
1. PLACE OF DEATH a. COUNTY <u>St Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MO</u> b. COUNTY <u>St Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Koch</u>		c. LENGTH OF STAY (in this place) <u>46 mos</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>Robert Koch Hospital</u>				STREET ADDRESS (If rural, give location) <u>18 3559 Caroline 2181</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Reba</u> b. (Middle) <u>Hell</u> c. (Last) <u>Hell</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 4 1956</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>		8. DATE OF BIRTH <u>12-5-04</u>	
9. AGE (In years last birthday) <u>51</u>		IF UNDER 1 YEAR Months <u>2</u>		IF UNDER 24 HRS. Hours _____		IF UNDER 10 MIN. Minutes _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Office Clerk</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Cuba, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Charles Hell</u>		13b. MOTHER'S MAIDEN NAME <u>Lucy McCracken</u>		14. NAME OF HUSBAND OR WIFE <u>Ramon Valdon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>HOSPITAL RECORD, KOCH HOSPITAL</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, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>chronic pulmonary tuberculosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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>22 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>002x</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) (m.)		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>April 8, 1952</u> , to <u>Feb 4, 1956</u> , that I last saw the deceased alive on <u>Feb 4, 1956</u> , and that death occurred at <u>5:10 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Frank Cohen M.D.</u>		23b. ADDRESS <u>Robert Koch Hospital</u>		23c. DATE SIGNED <u>2-4-56</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>2-6-1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Rolla Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Rolla Mo.</u>	
DATE REC'D BY LOCAL REG. <u>2-5-56</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Donohed</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Attila Hanklin Cuba, Mo</u>			

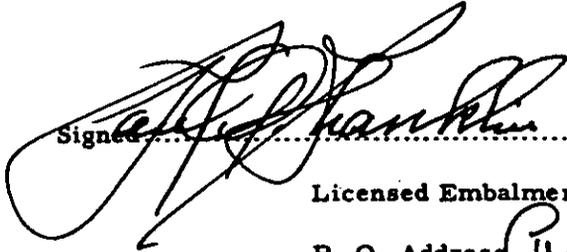
Dr. (Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed.....


Licensed Embalmer No. 347

P. O. Address Cuba, Mo.

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.