

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 24 1956

28122

STATE FILE NUMBER

6746

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5909 Cates Ave		Length of stay in lb 23 Yrs	d. STREET ADDRESS (If outside, give location) 5909 Cates Ave		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Ruby Bell			4. DATE OF DEATH July 17, 1956		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 18, 1886	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Corinth, Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Jacob Bell			14. MOTHER'S MAIDEN NAME Alice Nash		
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 Mr O. H. Bill 5909 Cates Ave (husband)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion DUE TO (b) Coronary heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 1 day 10 months
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 42.0.1				
20c. TIME OF INJURY. Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE	
21. I attended the deceased from May 26, 1956 to July 17, 1956 and last saw her alive on July 17, 1956 Death occurred at 2:50 A.M. m on the date stated above; and to the best of my knowledge from the causes stated.					
22a. SIGNATURE (Degree or title) Norton John Eversoll, M.D.		22b. ADDRESS 6356 Clayton Road		22c. DATE SIGNED July 17, 1956	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Rail	23b. DATE 7/18/56	23c. NAME OF CEMETERY OR CREMATORY Henry, Cemetery	23d. LOCATION (City, town, or county) (State) Corinth, Mississippi		
24. FUNERAL DIRECTOR Alexander & Sons 6175 Delmar Blvd		ADDRESS	25. DATE RECD. BY LOCAL REG. JUL 18 1956	26. REGISTRAR'S SIGNATURE Carl Smith, MD	

(Licensed Embalmer's Statement on Reverse Side)

300 1-56
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

m 83

Dr. Norton J. Eversoll
6356 Clayton Rd
St. 1-4060
3 - 6 P.M.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Jos. E. McCulloch*

Licensed Embalmer No. *24*

P. O. Address *61752*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.