

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **9909**  
Registrar's No. **2341**

FILED MAR 27 1957

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>ILLINOIS</b> b. COUNTY <b>WAYNE</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST LOUIS</b>		c. CITY OR TOWN <b>WAYNE CITY</b>	
c. LENGTH OF STAY (in this place) <b>2 DAYS</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST LOUIS CHILDREN'S HOSP</b>		e. STREET ADDRESS (If rural, give location) <b>Box 97 BERRY TOWNSHIP</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>LARRY</b> b. (Middle) <b>Joe</b> c. (Last) <b>BELL</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>3 7-1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7-26-1943</b>
9. AGE (In years last birthday) <b>13</b>		IF UNDER 1 YEAR Months	IF UNDER 1 HR. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Note</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Note</b>	
11. BIRTHPLACE (City and State or Foreign Country) <b>WAYNE COUNTY, ILL.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13a. FATHER'S NAME <b>JOE WM BELL</b>		13b. MOTHER'S MAIDEN NAME <b>HESTER DICCON</b>	
14. NAME OF HUSBAND OR WIFE <b>Note</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Grace Jones 500 S KINGS HIGHWAY</b>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Bilateral pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>490x</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <b>2</b> 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 <b>3-5</b> , 19 <b>57</b> , to <b>3-7</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3-7</b> , 19 <b>57</b> , and that death occurred at <b>3-40p.m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Barbara Jones, M.D.</b>		23b. ADDRESS <b>500 S KINGS HIGHWAY</b>	
23c. DATE SIGNED <b>3-7-57</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
24b. DATE <b>3-8-57</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Wayne City</b>	
24d. LOCATION (City, town, or county) (State) <b>Wayne City, Ill.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>E. St. Louis, Ill</b>	
DATE REC'D BY LOCAL REG. <b>MAR 8 '57</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b> (Licensed Embalmer's Statement on Reverse Side)	

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

S. No. 300  
V. 10.48

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 Not Embalmed, Student Embalmer No. .... working under my personal supervision:.

Student.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No. 7574

P. O. Address E. H. Down

- 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.