

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 7 1957

318

18435
State File No. 4471
1003 Registrar's No.

BIRTH NO. REG. DIST. NO. PRIMARY REG. DIST. NO.

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. 4798 b. COUNTY St. Louis ✓ c. CITY OR TOWN Webster Groves		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 3 days		
d. FULL NAME OF HOSPITAL OR INSTITUTION 08 Deaconess Hospital		STREET ADDRESS (If rural, give location) 27 424 East Big Bend Rd.		

3. NAME OF DECEASED (Type or Print) a. (First) RUSSELL b. (Middle) ELIOT c. (Last) BELKNAP		4. DATE OF DEATH (Month) (Day) (Year) May 8, 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 10, 1918
9. AGE (In years last birthday) 39		10. KIND OF BUSINESS OR INDUSTRY Laclede Gas Co.	11. BIRTHPLACE (City and State or Foreign Country) / Worcester, Mass.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Clifton Belknop		13b. MOTHER'S MAIDEN NAME Hilia Paakonon		14. NAME OF HUSBAND OR WIFE Sarah Belknop	
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. —		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Sarah Belknop 424 E. Big Bend	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Insufficiency 30 minutes ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Obesity. DUE TO (b) DUE TO (c) (Heridity - Small coronary vessel) Acute pylorospasm		INTERVAL BETWEEN ONSET AND DEATH 30 minutes	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 420.1		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 5-5, 1957, to 5-8, 1957, that I last saw the deceased alive on 5-8, 1957, and that death occurred at 9:30p m., from the causes and on the date stated above.

23a. SIGNATURE Grant Linnihan M.D.		(Degree or title)		23b. ADDRESS 731 E. Big Bend Webster Groves Mo.		23c. DATE SIGNED 5-9-57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-11-1957		24c. NAME OF CEMETERY OR CREMATORY LOCAL		24d. LOCATION (City, town, or county) (State) Rockport, Mass.	

DATE REC'D BY LOCAL REG. MAY 10 57		REGISTRAR'S SIGNATURE [Signature]		FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS [Address]	
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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 *Leslie Welch*

Licensed Embalmer No. *439*

P. O. Address *Webster, Iowa*

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.