Health, & Welfare Public Service

S. 300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-024117
STATE FILE NUMBER

FILED JUL 11 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1701

1. PLACE OF DEATH a. COUNTY St. Louis	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS COUNTY — Inside Limits Yes ☐ No ☒	c. CITY OR TOWN ST LOUIS COUNTY 41300 — Inside Limits Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 9858 Winkler Dr. — Length of stay in lb 9 wks	d. STREET ADDRESS (If outside, give location) 9858 Winkler Dr. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First JAMES Middle THOMAS Last BELL

4. DATE OF DEATH Month June Day 25, Year 1958

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH APRIL 21, 1958

9. AGE (In years last birthday) 0 — IF UNDER 1 YEAR Months 2 Days 4 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (City and state or country) St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME John Thomas Bell

13b. MOTHER'S MAIDEN NAME Jeannette Douglas

14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT John T. Bell, Address 9858 Winkler Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congenital Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 9 wks

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)

DUE TO (c) 754.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 4-21-58, to 6-25-58 and last saw her/him alive on 6-17-58

Death occurred at 6 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) M D Johnson M D

22b. ADDRESS Ferguson, Mo.

22c. DATE SIGNED 6-25-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 6/26/58

23c. NAME OF CEMETERY OR CREMATORY Memorial PK. Cem.

23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.

24. FUNERAL DIRECTOR WHITE-MULLEN ADDRESS 1518 N. Florissant Rd.

25. DATE RECD. BY LOCAL REG. 6-25-58

26. REGISTRAR'S SIGNATURE Herbert R. Domke M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 Eleanor Lovine

Licensed Embalmer No. 3403

P. O. Address Jamaica N

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.