

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-037597

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar No. 10274

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jewish Hospital</u>		Length of stay in lb <u>3 days</u>	d. STREET ADDRESS (If outside, give location) <u>6251 Delmar</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MORRIS</u> Middle Last <u>BELL</u>			4. DATE OF DEATH Month <u>October</u> Day <u>27</u> Year <u>1958</u>		
--	--	--	---	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 21, 1893</u>	9. AGE (In years last birthday) <u>65</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
-----------------------	----------------------------------	---	---	--	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>City Inspector</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Weights Dept.</u>	11. BIRTHPLACE (City and state or country) <u>Russia</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
--	---	---	--

13a. FATHER'S NAME <u>Jacob Bell</u>	13b. MOTHER'S MAIDEN NAME <u>Eve (unknown)</u>	14. NAME OF HUSBAND OR WIFE <u>Molly</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> <u>None</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT Address <u>Molly Bell 6251 Delmar Avenue</u>
--	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) <u>332x</u>		
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 <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.)
---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <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 <u>JAN 19, 1951</u> to <u>10/27/58</u> and last saw him alive on <u>10/26/58</u> Death occurred at <u>12:55 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE <u>David Feldman M.D.</u> (Degree or title)	22b. ADDRESS <u>539 N. GRAND</u>	22c. DATE SIGNED <u>10/27/58</u>
---	-------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10/28/1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emeth</u>	23d. LOCATION (City, town, or county) (State) <u>University City, Missouri</u>
---	--------------------------------	--	---

24. FUNERAL DIRECTOR <u>Berger Memorial 4715 McPherson Ave.</u>	25. DATE RECD. BY LOCAL REG. <u>OCT 27 '58</u>	26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, m.d.</u>
--	---	---

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

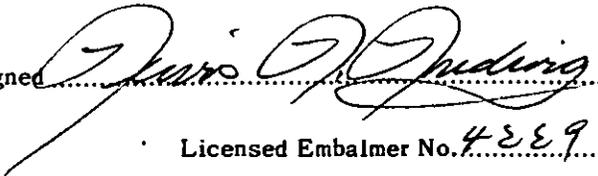
MEDICAL CERTIFICATION

300 0  
1-57

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. 4339 .....  
P. O. Address .....

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.