Health, Welfare & Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002723
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 136

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1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: 915 N.GRAND, ST.LOUIS, MO. — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: VET.ADM. HOSPITAL — Length of stay in 1b: 11 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI
b. COUNTY:
c. CITY OR TOWN: ST. LOUIS — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 2218 ½ BENTON — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print)
First: WILLIAM Middle: W. Last: BELL

4. DATE OF DEATH Month Day Year: JANUARY 6, 1959

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]
8. DATE OF BIRTH: 8/20/~~19~~ 1902
9. AGE (In years last birthday): 56 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK & DRIVER
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Post Office
11. BIRTHPLACE (City and state or country): ST. LOUIS, MO.
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: JOHN J. BELL
13b. MOTHER'S MAIDEN NAME: FLORA MC DONALD
14. NAME OF HUSBAND OR WIFE: GRACE BELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW-1
16. SOCIAL SECURITY NO.: 321-18-7918
17. INFORMANT Address: VA HOSP. RECORDS, ST. LOUIS, MO.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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): PNEUMONIA, CAUSATIVE ORGANISM — INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): PSEUDOMONAS — 11 days
DUE TO (c): OBSTRUCTIVE EMPHYSEMA — UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): ANEMIA, MACROCYTIC - CAUSE UNKNOWN. 527.1
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

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 12/26/58, to 1/6/59 and last saw him alive on 1/6/59
Death occurred at 12:10 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): LEO T. NEU JR. M.D.
22b. ADDRESS: VAH, ST. LOUIS, MO.
22c. DATE SIGNED: 1/6/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 1/9/58
23c. NAME OF CEMETERY OR CREMATORY: St. Peters Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Co, Mo.

24. FUNERAL DIRECTOR: Robert D. Kinealy
ADDRESS: 2228 St. Louis
25. DATE RECD. BY LOCAL REG.: JAN 6 '59
26. REGISTRAR'S SIGNATURE: J. Earl Smith M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

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 Elton B. H. Remelius

Licensed Embalmer No. 4283

P. O. Address St. Louis Mo

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.