

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011175
STATE FILE NUMBER
2 2328
REGISTRAR'S NO.

FILED MAR 30 1959

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>ST. LOUIS</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>City of St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>4000 Times Beach</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>MO. BAPTIST HOSP.</i>		Length of stay in 1b <i>1 DAY</i>	d. STREET ADDRESS (If outside, give location) <i>324 Birch RD.</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>ROBERT</i> Middle <i>LEE</i> Last <i>MANESS</i>			4. DATE OF DEATH Month <i>MARCH</i> Day <i>4</i> Year <i>1959</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 28, 1880</i>	9. AGE (In years last birthday) <i>79</i> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Minster</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Minster</i>	11. BIRTHPLACE (City and state or country) <i>St. Clair, Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>not known</i>			14. MOTHER'S MAIDEN NAME <i>Not Known</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Wife - Nellie Maness Times Beach, Mo.</i>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure with</i> <i>Arteriosclerotic Heart Disease</i> DUE TO (b) <i>with pleural effusion - left bundle branch block</i> DUE TO (c) <i>42 D.O.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>235 pm 3-4</i> <i>clock 11:50 pm 3-4</i>
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 checked="" type="checkbox"/> NO <input 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 Month, Day, Year a. m. p. m.		20d. INJURY OCCURRED WHILE AT WORK <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 <i>3-4-59</i> to <i>3-4-59</i> and last saw him alive on <i>3-4-59</i> Death occurred at <i>11:50</i> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <i>Wm Bailey</i>	22b. ADDRESS <i>St Louis, Mo 407 Theater Bldg 819</i>	22c. DATE SIGNED <i>3-5-59</i>

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>7-March-1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Prospect Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Lonedell, Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>B Bell - Bell Funeral Home - Pacific</i>		25. DATE RECD. BY LOCAL REG. <i>MAR 6 '59</i>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>

(Licensed Embalmer's Statement on Reverse Side)

with, office, public, service, 00, 56, S, 4000, 0, diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

MEDICAL CERTIFICATION

MAR 30 1959

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~~ Byron J Bell....., Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Byron J Bell.....
Licensed Embalmer No. 44
P. O. Address Pacific

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.