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

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| 3. NAME OF DECEASED (Type or print) First Middle Last Ward Joseph Bellow | | | 4. DATE OF DEATH Month Day Year November 18, 1960 | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 9/23/88 | 9. AGE (last birthday) 72 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY --- | 11. BIRTHPLACE (City and state or country) near O'Fallon, Mo. | 12. CITIZEN OF WHAT COUNTRY U. S. | |
| 13a. FATHER'S NAME Charles Philip Bellow | | 13b. MOTHER'S MAIDEN NAME Mary Elizabeth Lushia | | 14. NAME OF HUSBAND OR WIFE none | |

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown | 16. SOCIAL SECURITY NO. 486-14-4397 | 17. INFORMANT Masonic Home of Missouri <i>John Robertson, Jr.</i> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) | Cerebral Hemorrhage | 5 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Generalized Arteriosclerosis | unknown |
| | DUE TO (c) 331X | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
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| 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.) --- |
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| 20c. TIME OF INJURY Hour a.m. p.m. --- | Month, Day, Year --- |
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| 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 3/10/58 to 11/18/60 and last saw ^{DECEASED}him alive on 11/18/60
 Death occurred at 2:50 pm on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <i>Harold E. Walters M.D.</i> | 22b. ADDRESS 3720 Washington St. Louis | 22c. DATE SIGNED 11-18-60 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 11-18-60 | 23c. NAME OF CEMETERY OR CREMATORY Local | 23d. LOCATION (City, town, or county) OFallon, Mo |
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| 24. FUNERAL DIRECTOR Keithley OFallon, Mo | 25. DATE RECD. BY LOCAL REG. NOV 21 1960 | 26. REGISTRAR'S SIGNATURE <i>Roald Smith M.D.</i> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 29 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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