

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-038288

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10392

AMENDED FILED NOV 15 1961

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>		Length of stay in 1b		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3639 Windsor Pl.</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3639 Windsor Pl.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>(nmn)</u> Last <u>BELL</u>				4. DATE OF DEATH <u>Nov 4, 1961</u> Month Day Year									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</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>4/3/88</u>		9. AGE (last birthday) <u>73</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Keeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Delicatessen</u>		11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>Bon Tillery Bell</u>				13b. MOTHER'S MAIDEN NAME <u>Unavailable</u>				14. NAME OF HUSBAND OR WIFE <u>Edith O. Bell</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>						17. INFORMANT Address <u>Edith O. Bell, 3639 Windsor Pl.</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>Cardio Renal Vascular Disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____										<u>442x</u>			
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
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. Month, Day, Year													
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 <u>Oct 22, 1961</u> to <u>Nov. 4, 1961</u> and last saw her/him alive on <u>Nov. 4, 1961</u> Death occurred at <u>10:10</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Frayne D. Alexander M.D.</u>						22b. ADDRESS <u>1363 N. Union Blvd.</u>				22c. DATE SIGNED <u>11/7/61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>11/9/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olive Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Lemay, Mo.</u>							
24. FUNERAL DIRECTOR ADDRESS <u>Cunningham & Moore, 2405 Marcus</u>				25. DATE RECD. BY LOCAL REG. <u>NOV 8 1961</u>		26. REGISTRAR'S SIGNATURE <u>Lead Smith, M.D.</u>							

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

