DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
REC'D AUG 11 1939

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23880

Registration District No. 791

Primary Registration District No.

Registrar's No. 6153

1. PLACE OF DEATH: 1003

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 175 22nd St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community 15 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

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(d) Street No. 17 S. 22nd St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years

3. (a) PRINT FULL NAME Hazel Cooley 4003

3. (b) If veteran, name war no

3. (c) Social Security No. nil

4. Sex F

5. Color or race C

6. (a) Single, widowed, married, divorced Married Separated

6. (b) Name of husband or wife Unk.

6. (c) Age of husband or wife if alive Unk. years

7. Birth date of deceased Nov. (Month) 12, (Day) 1900 (Year)

8. AGE: Years 38 Months 7 Days 28 If less than one day hr. min.

9. Birthplace Lexie (City, town, or county) Arkansas (State or foreign country)

10. Usual occupation Nil

11. Industry or business

FATHER 12. Name John Davis

13. Birthplace Parkin (City, town, or county) Arkansas (State or foreign country)

MOTHER 14. Maiden name Minnie Boston

15. Birthplace Parkin (City, town, or county) Arkansas (State or foreign country)

16. (a) Informant's own signature Lucye Atkins

(b) Address 175 22nd St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/13/39 (Month) (Day) (Year)

(c) Place: burial or cremation E. St. Louis, Ill

18. (a) Signature of funeral director D. M. Green

(b) Address 3517 Lucede ave

19. (a) JUL 12 1939 (Date received local registrar) (b) J. F. Pechuck (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10th year 39 hour 6 minute 8 A. M.

21. I hereby certify that I attended the deceased from July 3rd 39, 19, to July 10 39, 19, that I last saw her alive on July 10 39, 19, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebrovascular hemorrhage with hemiplegia	1 wk 6 d
Due to: Mitral regurgitation & Heart failure	some years
Due to: Cause of hypertension not determined	
Other conditions: Heat stroke (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work (e) Means of injury

23. Signature J. P. Wheelock (M. D. or other)

Address 2704 Fairfax Date signed

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed: [signature]

Licensed Embalmer No. 1173

P. O. Address 3517 Sorlede C

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.