

LED MAR 30 1943 18
Registration District No.

Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **St. Louis, Missouri**
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 days**
(Specify whether
In this community **38 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1708 Cole**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Arthur Cox**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Bessie** 6. (c) Age of husband or wife if alive **67** years

7. Birth date of deceased **Feb. 8, 1875**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 1 8 hr. min.

9. Birthplace **Tenn.**
(City, town, or county) (State or foreign country)

10. Usual occupation **file**

11. Industry or business

MOTHER FATHER { 12. Name **Unknown**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Bessie Cox**
(b) Address **1708 Cole St.**

17. (a) **Burial** (b) Date thereof **Mar. 22/43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **Dement & Son**
(b) Address **2629-33 1 Cole St.**

19. (a) **1943** (b) **J. F. Budeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **16**,
year **1943** hour **5** minute **25 A.** M.

21. I hereby certify that I attended the deceased from **March 9, 1943** to **March 16, 1943**
that I last saw him alive on **March 16, 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration **7 days**

Due to **8/3**
Due to

Other conditions (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?

While at work? (Specify type of place) (e) Means of injury.....

23. Signature **P. E. Smith** (M. D. or other)
Address **2601 Shuttler** Date signed **3/17/43**

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 *William Claude Gordon*

Licensed Embalmer No. *3489*

P. O. Address *4575 Aldine St.*

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 this body is not embalmed, fact should be so stated above.