

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **201**
Registrar's No. **1126**

Registration District No. **18** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County **St. Louis, Mo**
(b) City or town **St. Louis, Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **24 days** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Earl Robert Cosgrove**
3. (b) If veteran, name war **None** **3. (c) Social Security No.** **Unknown**
4. Sex **Male** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** **Single**
6. (b) Name of husband or wife **6. (c) Age of husband or wife if alive** years
7. Birth date of deceased **Dec. 13 1924**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
19 **1** **20** hr. min.

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

10. Usual occupation **Unemployed**

11. Industry or business

12. Name **William Cosgrove**

13. Birthplace **Unknown Indiana**
(City, town, or county) (State or foreign country)

14. Maiden name **Helen Brewer**

15. Birthplace **Unknown Indiana**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Wm. Cosgrove**

(b) Address **Montgomery, Indiana**

17. (a) Removal **(b) Date thereof** **2-4-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Montgomery, Indiana**

18. (a) Signature of funeral director **Albert H. Hoppe, Inc.**

(b) Address **4700 Washington Blvd.**

19. (a) (Date received local registrar) **FEB 3 1944** **(Registrar's signature)** **J. F. [Signature]**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Indiana** (b) County **Daviess**
(c) City or town **Montgomery**
(If outside city or town limits, write "RURAL") **NR**
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country **2**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **3** year **1944** hour **1** minute **15** A. M.
21. I hereby certify that I attended the deceased from **January 10**, 19**44**, to **February 3**, 19**44**
that I last saw him alive on **February 3**, 19**44**, and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia on right**
Due to **Bronchitis, cavity R. H. L.**
Due to _____
Other conditions **110**
(Include pregnancy within 3 months of death)

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____

Of autopsy **Pt. Pneumonia, Bronchitis, cavity R. H. L.**

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 **M. C. Albert** (M. D. or other) **BARNES HOSPITAL**
Address _____ Date signed **2/3/44**

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

Albert Hopper

Licensed Embalmer No. *1861*

P. O. Address.....

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.