

FILED AUG 11 1945

Registration District No. _____

Primary Registration District No. 3063

Registrar's No. 1980

1. PLACE OF DEATH

(a) County St. Louis County
 (b) City or town Clayton, Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Louis County Hosp.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 months - 2 days
(Specify whether)
 In this community 7-8-45
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis Co. 96
 (c) City or town University City 3
(If outside city or town limits, write "RURAL")
 (d) Street No. 6600 Washington 5
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Kate O. Cole

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race wh 6. (a) Single, widowed, married, divorced widow
 6. (b) Name of husband or wife William J. Cole 6. (c) Age of husband or wife if alive dec. years
 7. Birth date of deceased 9 20 59
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 10 8 hr. _____ min.

9. Birthplace Monticello, Va. 1
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business None

MOTHER FATHER
 12. Name Richard Omehundra
 13. Birthplace Virginia!
(City, town, or county) (State or foreign country)
 14. Maiden name Matilda Clarkson
 15. Birthplace Virginia!
(City, town, or county) (State or foreign country)

16. (a) Informant Patience Kate O. Cole

(b) Address 6600 Washington Blvd.

17. (a) burial (b) Date thereof July 31-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla

18. (a) Signature of funeral director Alexander Gans

(b) Address 6175 Delmar Blvd. St. Louis, Mo.

19. (a) 8-6-45 (b) E. S. W. Garrison
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29
 year 1945 hour 5 minute 30 A. M.

21. I hereby certify that I attended the deceased from April 7 1945 to July 29 1945
 that I last saw her alive on July 29 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death HYPSTATIC PNEUMONIA Duration 4 days
 Due to FRACTURE RT. (HIP) FEMUR 3 1/2 Mo's

Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE
 Other conditions 1945
(Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED **PHYSICIAN**
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 134

(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 [Signature] (M. D. or other) _____
 Address St. Louis County, Mo. Date signed 7-29-45

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

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

Joseph E. McCulloch

Licensed Embalmer No. *2460*

P. O. Address *6170 Delmar*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24923
Registrar's No. 1942

Registration District No. 217 Primary Registration District No. 3063

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Kate O. Cole
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 20
(Month) (Day)

8. AGE: Years 85 Months 10 Days _____ If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country) Va

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death lobar pneumonia Duration 7 days

Due to fracture neck of right femur 3 mos

Due to osteomyelitis & reconstruction of fracture 5 days

Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: Of operations _____

Of autopsy _____
10/10

Duration

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) accident

(b) Date of occurrence 4/6/45

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

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

While at work? _____ (c) Means of injury fall

23. Signature [Signature] (Date received)

Address 601 Ashwood Apts Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

