

FILED JAN 21 1948

State File No. \_\_\_\_\_

Registration District No. 307

Primary Registration District No. 3069

Registrar's No. 18

**1. PLACE OF DEATH:**  
 (a) County ST LOUIS  
 (b) City or town RICH HTS MO  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
ST MARYS HOSP  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 6 hrs  
(Specify whether)  
 In this community 6 hrs  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State ILL (b) County ST CLAIR  
 (c) City or town MHSCOUTAH ILL  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 315 N 1<sup>st</sup> ST  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** AUSTIN DOUGLAS WHITECOTT  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month Dec day 31  
 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

4. Sex MO 5. Color or race W  
 6. (a) Single, widowed, married, divorced 0  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased DEC 31 1945  
(Month) (Day) (Year)

that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
 Immediate cause of death Intra-cranial Hemorrhage posterior fossa.  
 Duration \_\_\_\_\_

**8. AGE:** Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 5 hr. 50 min.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

9. Birthplace ST MARYS HOSP RICH HTS MO  
(City, town, or county) (State or foreign country)

Other conditions 8761  
(Include pregnancy within 3 months of death)

10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_

**MOTHER FATHER**  
 12. Name HOSEA A WHITECOTT  
 13. Birthplace SULLIVAN KENTUCKY  
(City, town, or county) (State or foreign country)  
 14. Maiden name VELMA LAUDER  
 15. Birthplace CARTERVILLE ILL  
(City, town, or county) (State or foreign country)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**PHYSICIAN** \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Hosea A Whitecotton  
 (b) Address 315 N 1<sup>st</sup> St Mascoutah Ill  
 17. (a) BURIAL (b) Date thereof JAN 2 - 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation OAKLAND CEM CARTERVILLE ILL

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? \_\_\_\_\_

18. (a) Signature of funeral director Walter Barker  
 (b) Address 6536 Oakton Rd  
 19. (a) 1-46 (b) ES M. [Signature]  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
 (c) Means of injury \_\_\_\_\_  
 23. Signature [Signature] (M, D. or other) \_\_\_\_\_  
 Address Inter City St. Louis Mo Date signed 1-1-48

**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..... *Gay W Wilkins*

Licensed Embalmer No..... *3575*

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.**

Registration District No. 317

Primary Registration District No. 3069

Registrar's No. 18

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Richmond Heights  
(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 \_\_\_\_\_ (month, months or days)

3. (a) PRINT FULL NAME Austin D. Whitecotton

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec 31 (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. 5 min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) mo

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 \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 2-18-46 (Date received local registrar) (b) E. M. Garrison M.D. (Registrar's signature) MSC

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 45 hour \_\_\_\_\_ minute 50 AM

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19 \_\_\_\_\_

that I last saw him \_\_\_\_\_ all over \_\_\_\_\_, 19 \_\_\_\_\_

and that death occurred on the date and hour stated above, immediate cause of death \_\_\_\_\_

Intracranial hemorrhage, teleclon patient, food when vomit.

Due to \_\_\_\_\_

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 Phyllis (M. D. or other) \_\_\_\_\_

Address 2000 Date signed \_\_\_\_\_

SUPPLEMENTARY

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

D  
5  
3880

4192