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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **38519**  
Registrar's No. **9705**

FILED NOV 25 1946

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County **ST Louis**  
(b) City or town **ST Louis**  
(c) Name of hospital or institution:  
**Homer Phillips Hospital**  
(d) Length of stay: In hospital or institution **19 yrs**  
In this community **19 yrs**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo** (b) County **ST Louis**  
(c) City or town **ST Louis**  
(d) Street No. **108 N 22nd ST**  
(e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **Idella Cox Daniels**  
3. (b) If veteran, name year **No**  
3. (c) Social Security No. \_\_\_\_\_

5. Color or race **Female Col**  
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 **7 5 1912**

8. AGE: Years **34** Months **4** Days **4**  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Memphis TENN**

10. Usual occupation **Sorter**

11. Industry or business **Superior Laundry**

12. Name **HARRISON COX**

13. Birthplace **TENN**

14. Maiden name **IDA TAYLOR**

15. Birthplace **TENN**

16. (a) Informant **Mary Jackson**

(b) Address **2203 Market St**

17. (a) (b) Date thereof **11-15-46**

(c) Place: burial or cremation **Greenwood**

18. (a) Signature of funeral director **Ben Williams**

(b) Address **3103 Washington**  
19. (a) **NOV 14 1946** (b) **J. F. Brueck**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Nov** day **9**  
year **1946** hour **8** minutes **40** A.M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Due to **Lobar Pneumonia**  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) **108**  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_  
23. Signature **Arthur E. Dwyer** (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ signed \_\_\_\_\_

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

MOTHER FATHER

**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 *M. Claude Gordon*

Licensed Embalmer No. *9489*

P. O. Address *4575 Aldene*

**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.**