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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7363

FILED MAR 14 1947

Registration District No. 6

Primary Registration District No. 6076

Registrar's No. 564

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Veterans Administration Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: Since 2-25-47 (Specify whether years, months or days)

In this community: 15 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Illinois (b) County: St. Clair 999

(c) City or town: East St. Louis 11
(If outside city or town limits, write "RURAL")

(d) Street No.: 100 South 8th Street 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 2

If yes, name country:

3. (a) PRINT FULL NAME: COX, Peter

3. (b) If veteran, name war: World I

3. (c) Social Security No.: Unknown

4. Sex: Male 2

5. Color or race: Negro

6. (a) Single, widowed, married, divorced: Widowed.

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: March 21, 1896 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
50	11	11	2 hr. 10 min.

9. Birthplace: Jackson, Tennessee (City, town, or county) / (State or foreign country)

10. Usual occupation: Butcher

11. Industry or business:

MOTHER FATHER

12. Name: Ben. Cox

13. Birthplace: Tennessee (City, town, or county) / (State or foreign country)

14. Maiden name: Nellie Rooks

15. Birthplace: Tennessee (City, town, or county) / (State or foreign country)

16. (a) Informant: Registrar, Veterans Adm. Hospital,

(b) Address: Jefferson Barracks, Missouri.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 3/8/47 (Month) (Day) (Year)

(c) Place: burial or cremation: E. St. Louis, Ill.

18. (a) Signature of funeral director: R.M.C. Green Und. Co.

(b) Address: East St. Louis, Illinois

19. (a) 3-10-47 (Date received local registrar) (b) Ruth Allen MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5, year 1947 hour 2:10 minute AM.

21. I hereby certify that I attended the deceased from February 25, 1947 to March 5, 1947; that I last saw him alive on March 5, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death: SUB ARACHNOID HEMORRHAGE — Duration: UNK.

Due to: 131

CONTRIBUTORY: Hypertension, arterial, etiology undetermined; chronic nephritis, type undetermined.

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

Major findings: Of operations: No Operation

Of autopsy: Autopsy performed. (See cause of death.)

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): No

(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? (Specify type of place)

While at work? (Specify) Means of injury: 0

23. Signature: L. E. Stilwell (L. E. STILWELL, M.D.) (M. D. or other)

Address: Vet. Adm. Hosp., Jeff. Bks., Mo. Date signed: 3-5-47

(Licensed Embalmer's Statement on Reverse Side)

MAY 22 1947

MAY 22 1947

APR 22 1947

APR 2 1947

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 [signature]

Licensed Embalmer No. 1173

P. O. Address 3517 Laclede Ave

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.