

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15907
Registrar's No. 880

FILED APR 23 1947

Registration District No. 277

Primary Registration District No. 2064

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town Ferguson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
172 S. Flourens Rd.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)
4 months

3. (a) PRINT FULL NAME HERBERT COCKER.

8. (b) If veteran, name war XXXX 3. (c) Social Security No. XXXXXX

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife CORINNE 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Dec. 9 1881
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 4 7 hr. min.

9. Birthplace Kinslejr city, Kansas
(City or town and county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Agriculture

12. Name John J Cocker

13. Birthplace Lancaster England
(City or town and county) (State or foreign country)

14. Maiden name Mary Ogle

15. Birthplace St. Clair Illinois
(City or town and county) (State or foreign country)

18. (a) Informant's own signature Mrs. Viola Schmitt

(b) Address 809 Indiana av. St. Louis

17. (a) Shiloh Ill. (b) Date thereof April 20, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shiloh Ill.

18. (a) Signature of funeral director M. Hillenburger

(b) Address O'Fallon Illinois

19. (a) 4-18-47 (b) Bevila J. Shapiro
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County St. Clair
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. R R # 2 O'Fallon, Ill
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16 year 1947 hour 6:40 minute _____ M.

21. I hereby certify that I attended the deceased from December 1946 to April 16, 1947, that I last saw him alive on 16 April 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion with myocardial infarction
Due to Hypertensive cardiac vascular renal disease

Due to _____
Other conditions (Include pregnancy within 3 months of death) 1316

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
Signature John J. Cocker (M. D. or other) MD
Address 902 S. Flourens Ferguson Date signed 4/16/47

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FORM 1 (1935)

SEP 9 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..... *Etton R. Remelino*.....

Licensed Embalmer No. *4283*.....

P. O. Address..... *W. Fallow Illinois*.....

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, above space should be left blank.