

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
100327596
State File No.
Registrar's No. 7296

Registration District No. 318

Primary Registration District No.

1. PLACE OF DEATH:

- (a) County St. Louis mo
(b) City or town St. Louis mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Marys Infirmary
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Days (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Corrie Cole3. (b) If veteran,
name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race apl 6. (a) Single, widowed, married, divorced mar.
6. (b) Name of husband or wife Allen Cole 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased Feb 25 1891
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 57 5 24 hr. - min.

9. Birthplace Bolivar Tennessee
(City, town, or county) (State or foreign country)10. Usual occupation House Wife

11. Industry or business _____

12. Name Hale Harris
13. Birthplace Bolivar Tennessee
(City, town, or county) (State or foreign country)
14. Maiden name Mary Roper
15. Birthplace Bolivar Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant Aurelia Smith
(b) Address 2931 Landon
17. (a) Burial (b) Date thereof Aug 20
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Chicago Ill

18. (a) Signature of funeral director Davis and Brown
(b) Address 1415 Biddle St
19. (a) AUG 20 1948 (b) J. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo. (b) County foo
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1422 N. Vandeventer
11 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 1st
year 48 hour 9 minute 15 M.
21. I hereby certify that I attended the deceased from
7-6 48 to 8-15 48
that I last saw her alive on 8-17 48
and that death occurred on the date and hour stated above.
Immediate cause of death Carcinoma of breast
Duration 5 1/2

- Due to _____
Due to 50
Other conditions none
(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)
(c) Means of injury Walter H. Spensman MD
Address 1106 St. Louis Date signed 8/18/48

(Licensed Embalmer's Statement on Reverse Side)

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 Char. L. Hance

Licensed Embalmer No. 2452

P. O. Address 2824 Gamble

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No.

Primary Registration District No. 1003

Registrar's No. 7296

1. PLACE OF DEATH:

- (a) County St Louis
(b) City or town St Louis
(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)

3. (a) PRINT FULL NAME Conie Lee

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

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

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

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

8. AGE: Years Months Days (Less than one day) hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) J. F. Brance (Registrar's signature)

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 Aug year 1948 hour minute M.

21. I hereby certify that I attended the deceased from to 19.....
that I last saw him alive on 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death Duration

- 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) (c) Means of injury

23. Signature (M. D. or other)
Address Date signed

SEP 4 1948

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