

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31224**

FILED OCT 9 1948

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **8530**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **22 hrs. 55 mins**
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Robert Lee McCottrell**

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

4. Sex **Male** 2 5. Color or race **Negro** 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 **8 29 48**
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day **22 hr. 55 min.**

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name **Marie McCottrell**
15. Birthplace **Starkville Mississippi**
(City, town, or county) (State or foreign country)

16. (a) Informant **Father M. Sherard, H.K.L.**
(b) Address **2601 N. Whittier**

17. (a) **Anatomical Board** (b) Date thereof **SEP 30 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Anatomical Board**

18. (a) Signature of funeral director **Roland Mortuary Service**
(b) Address **404 Manchester**

19. (a) **SEP 30 1948** (b) **J. F. Breese**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3429 Delmar**
(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 **30**
year **1948** hour **11** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **12:50 A.M. 8-29-**
1948 to **11:45 P.M. 1948**
that I last saw him alive on **8-30-**
and that death occurred on the date and hour stated above.

Immediate cause of death **Congenital Atelectasis**

Due to _____
Due to **161 a**
Other conditions _____
(Include pregnancy within 3 months of death)

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?

(Specify type of place) While at work? _____ (e) Means of injury **6**
23. Signature **W. J. Simpkins** (M.D. or other) **9-8-48**
Address **2601 N. Whittier** Date signed _____

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.....

Licensed Embalmer No.....

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.