

FILED MAY 23 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18061

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 991

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL - LEMAY</u> c. LENGTH OF STAY (In this place) <u>10 YRS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SAPPINGTON - RURAL - LEMAY TWP</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>NONE</u>		d. STREET ADDRESS (If rural, give location) <u>ROUTE 6 - SAPPINGTON MO</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>PERCY</u> b. (Middle) <u>WELLS</u> c. (Last) <u>COBB</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 17 1949</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 20 - 1873</u>	9. AGE (In years last birthday) <u>75</u>	if UNDER 1 YEAR Months Days	if UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOCTOR - RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RESEARCH</u>	11. BIRTHPLACE (State or foreign country) <u>CLEVELAND OHIO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>		

13a. FATHER'S NAME <u>BRUTUS J. COBB</u>	13b. MOTHER'S MAIDEN NAME <u>ROSE BILL</u>	14. NAME OF HUSBAND OR WIFE <u>MARY G COBB</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WORLD WAR #1</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Fatherine Nash Cobb</u> ADDRESS _____

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  <u>?</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Degenerative Heart Disease</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Asthma</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>4-5-2 241X</u>			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR _____

22. I hereby certify that I attended the deceased from Oct 1930, to April 17, 1949, that I last saw the deceased alive on April 16, 1949, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Samuel D. Thompson MD</u>	23b. ADDRESS <u>634 No. Grand Blvd. St. Louis</u>	23c. DATE SIGNED <u>4-18-49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	24b. DATE <u>APRIL 19-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>VALHALLA CREMATORY</u>
DATE REC'D BY LOCAL REG. <u>4-18-49</u>	REGISTRAR'S SIGNATURE <u>Therid V. Lunnigan MO</u>	24d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u>
25. FUNERAL DIRECTOR'S SIGNATURE <u>Therid V. Lunnigan MO</u>		ADDRESS <u>Web Groves MO</u>

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

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0  
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JUN 24 1949

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.....

Student Embalmer No. ....

working under my personal supervision.

Signed.....

*Leslie Welch*

Signed.....

Student Embalmer

Licensed Embalmer No. ....

*4395*

P. O. Address.....

*Hoboken, New Jersey*

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.