

FILED AUG 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24698**
6655

318 **1003**
HOMER G. PHILLIPS HOSPITAL

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ REGISTRAR'S No. _____

293

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 25 yrs.		d. STREET ADDRESS (If rural, give location) 27 - 2810a Franklin Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Virginia	b. (Middle)	c. (Last) Cole	4. DATE OF DEATH (Month) (Day) (Year) 7 - 31 - 1949
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5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 8-12-1899	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Meridian Mississippi	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Cal Hall	13b. MOTHER'S MAIDEN NAME Fannie Young	14. NAME OF HUSBAND OR WIFE Aaron Cole
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Leroy Cole	ADDRESS 1242a Bayard Ave.
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Insufficiency		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) 93
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4222
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **4:50 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Walter Perry Dupuy (Degree or title)	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 8/11/49
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24a. BURIAL CREMATION REMOVAL (Specify) Burial	24b. DATE 8-5-1949	24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Missouri
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DATE REC'D BY LOCAL REG. AUG 1 1949	REGISTRAR'S SIGNATURE J. B. Sasser	25. FUNERAL DIRECTOR'S SIGNATURE Ellis Funeral Home	ADDRESS 2820 Stoddard St.
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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.

Student
Student Embalmer

Signed Fulton E. Oulkin

Licensed Embalmer No. 4198

P. O. Address Henri 13, Mo

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.