

FILED MAY 23 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18064

State File No. ....

|   |  |  |                             |  |  |   |  |                                  |  |
|---|--|--|-----------------------------|--|--|---|--|----------------------------------|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <b>318</b>  |                             | PRIMARY REG. DIST. NO. <b>1003</b>   |  | Registrar's No. <b>4276</b>   |  |                                  |  |
| 1. PLACE OF DEATH<br>a. COUNTY  |  |  |                             | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE<br><b>Missouri</b><br>b. COUNTY |  |   |  |                                  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <b>St. Louis</b>   |  | c. LENGTH OF STAY (In this place)  |                             | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <b>St. Louis</b>                                |  | <b>2219</b>   |  |                                  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Homer G Phillips Hospital</b>   |  |  |                             | d. STREET ADDRESS (If rural, give location)<br><b>2630 Lawton Blvd.</b>  |  |   |  |                                  |  |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First)<br><b>Ben</b>  |  |  | b. (Middle)<br><b>Cobbs</b> |  |  | c. (Last)<br><b>Cobbs</b>   |  |                                  |  |
| 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><b>May 5 1950</b>   |  | 5. SEX<br><b>male</b>  |                             | 6. COLOR OR RACE<br><b>Colored</b>   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>            |  |                                  |  |
| 8. DATE OF BIRTH<br><b>Dec. 2, 1897</b>   |  | 9. AGE (In years last birthday)<br><b>52</b>   |                             | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>potter</b>                        |  | 11. BIRTHPLACE (State or foreign country)<br><b>Anglon, Ark.</b>                    |  |                                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>potter</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Burkhart manufacture</b>                                       |                             | 11. BIRTHPLACE (State or foreign country)<br><b>Anglon, Ark.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?  |  |                                  |  |
| 13a. FATHER'S NAME<br><b>Ben Cobbs</b>  |  | 13b. MOTHER'S MAIDEN NAME<br><b>Bettie Williams</b>  |                             | 14. NAME OF HUSBAND OR WIFE<br><b>Agnes Cobbs</b>  |  |   |  |                                  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.  |                             | 17. INFORMANT'S SIGNATURE OR NAME<br><b>Agnes Cobbs 2950 Sheridan ave.</b>   |  |   |  |                                  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br><i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>  |  |  |                             | MEDICAL CERTIFICATION  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hypertensive Heart Disease with</b>   |  |  |                             | ANTECEDENT CAUSES<br><b>Congestive Failure</b>   |  |   |  | Undet.                           |  |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.  |  |  |                             | DUE TO (b) <b>None</b>   |  |   |  |                                  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><b>None</b>  |  |  |                             |  |  |   |  |                                  |  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION   |                             |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" 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?<br><b>H43X</b>  |  |   |  |                                  |  |
| 22. I hereby certify that I attended the deceased from <b>5-4</b> , 19 <b>50</b> , to <b>5-5</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>5-5</b> , 19 <b>50</b> , and that death occurred at <b>3 a</b> m., from the causes and on the date stated above. |  |  |                             |  |  |   |  |                                  |  |
| 23a. SIGNATURE<br><b>Steuers J. Nedrick</b><br>(Degree or title)<br><b>D. O.</b>  |  |  |                             | 23b. ADDRESS<br><b>2601 N Whittier St.</b>   |  | 23c. DATE SIGNED<br><b>5-6-50</b>   |  |                                  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>ship.</b>   |  | 24b. DATE<br><b>5 May 7, 1950</b>  |                             | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Little Rock, Ark.</b>   |  | 24d. LOCATION (City, town, or county) (State)                                       |  |                                  |  |
| DATE REC'D BY LOCAL REG.<br><b>MAY 12 1950</b>  |  | REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |                             | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>E. Walker</b><br>ADDRESS<br><b>503506 Franklin St. Louis Mo. et</b>                         |  |   |  |                                  |  |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY--USING 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 \_\_\_\_\_

working under my personal supervision.

Signed.....  
Student Embalmer

Signed

*W. Claude Gordon*

Student Embalmer No.....

Licensed Embalmer No. *3489*

P. O. Address *4575 Aldine*

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.