

THE DIVISION OF HEALTH OF MISSOURI  
FILED MAY 17 1950 STANDARD CERTIFICATE OF DEATH

18081  
State File No. 4179

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS, MISSOURI</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <u>ST. LOUIS, MISSOURI</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>ST. LOUIS 272<sup>9</sup></u>	
c. LENGTH OF STAY (as in hospital) <u>28 DAYS</u>		d. STREET ADDRESS (If rural, give location) <u>2306 Eugenia</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>BARNES HOSPITAL</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u>	b. (Middle) <u>-----</u>	c. (Last) <u>COTTON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 4, 1950</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 31, 1901</u>	9. AGE (In years last birthday) <u>48</u>	IF UNDER 1 YEAR Months	IF UNDER 6 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Macom, Mississippi</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>John Crosby</u>	13b. MOTHER'S MAIDEN NAME <u>Clines</u>	14. NAME OF HUSBAND OR WIFE <u>Tom Cotton</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Wm. Red Cotton</u>	ADDRESS <u>2306 Eugenia</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma Thyroid</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>metastasis to lungs</u> 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 checked="" 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) <u>1944</u>
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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?
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22. I hereby certify that I attended the deceased from APRIL 6, 1950, to MAY 4, 1950, that I last saw the deceased alive on MAY 4, 1950, and that death occurred at 12:30 P. M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>M. D. Hutchins</u>	23b. ADDRESS <u>Barnes Hosp</u>	23c. DATE SIGNED <u>5/5/50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Shipped</u>	24b. DATE <u>5/9/50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Macom, Miss</u>	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>J. B. Pasater</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. F. Home</u>	ADDRESS <u>215 So. Jefferson</u>
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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 certificat  was embalmed by me, or by \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed \_\_\_\_\_

*S. J. Hathorn*

Signed.....  
Student Embalmer

Licensed Embalmer No. *2690*

P. O. Address *2769 Chouteau*

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.