

FILED SEP 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28100**
7201
Registrar's No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	2269
d. FULL NAME OF HOSPITAL OR INSTITUTION: 1125 St. Louis Ave.		d. STREET ADDRESS (If rural, give location) 1125 St. Louis Ave 0	

3. NAME OF DECEASED (Type or Print)	a. (First) MARY	b. (Middle) CATHERINE	c. (Last) COX	4. DATE OF DEATH (Month) (Day) (Year) 8 24 50
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Feb. 23rd. 1871	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months Days	IF UNDER 6 WKS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Caledonia Mo	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Samuel Taylor	13b. MOTHER'S MAIDEN NAME Margaret Hull	14. NAME OF HUSBAND OR WIFE late Sidney Cox
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Walter Cox	ADDRESS 1227 Montgomery St.
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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 4 days 10-days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal Bronchopneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Congestive Heart failure DUE TO (c) Chronic Myocarditis + Nephritis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Vascular Cerebral accident 4 yrs ago			

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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 **Sept**, 19**49**, to **Aug 24**, 19**50**, that I last saw the deceased alive on **Aug 23**, 19**50**, and that death occurred at **3:30 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE John C. Creane	(Degree or title) M.D.	23b. ADDRESS 2504 N. 14th St.	23c. DATE SIGNED 8-24-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-26-1950	24c. NAME OF CEMETERY OR CREMATORY Zion Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County Mo
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DATE REC'D BY LOCAL REG. AUG 24 1950	REGISTRAR'S SIGNATURE J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE Leidner U.	ADDRESS 2223 St. Louis Ave.
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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 certificate was embalmed by me, or by _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer.

Signed Elmer R. Padwell

Licensed Embalmer No. 4077

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.