

FILED DEC 27 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42119**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10658**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin Desloge Hospital		d. STREET ADDRESS (If rural, give location) 6726 Waldemar	

3. NAME OF DECEASED (Type or Print) a. (First) Elizabeth b. (Middle) L. c. (Last) Cox			4. DATE OF DEATH (Month) (Day) (Year) 12-11-50		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 1-17-04		9. AGE (In years last birthday) 46		10. IF UNDER 1 YEAR (Specify) 10 Months 24 Days	
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) Mo.	
12. CITIZEN OF WHAT COUNTRY U.S.A.					

13a. FATHER'S NAME Ernest Briggerhorst		13b. MOTHER'S MAIDEN NAME Lillie Corlett		14. NAME OF HUSBAND OR WIFE William Cox	
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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) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS William Cox, above 6726 Waldemar	
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) HAENNEL'S CIRRHOSIS		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years	
		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. TUBERCULOUS PERITONITIS?		?	

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)	
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? 5811	

22. I hereby certify that I attended the deceased from **10-6-50** to **12-11-50**, 19____, that I last saw the deceased alive on **12-11-50**, 19____, and that death occurred at **8:30 P.M.** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M. L. Goehausen M.D.		23b. ADDRESS 1325 S. Grand, St. Louis 4, Mo.		23c. DATE SIGNED	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12-14-1950		24c. NAME OF CEMETERY OR CREMATORY St. Mathew's Ceme.	
				24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	

DATE REC'D BY LOCAL REG. DEC 14 1950		REGISTRAR'S SIGNATURE J. B. Lanter		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS JAY B. SMITH, 7456 Manchester Ave. Maplewood 17, Mo.	
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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 _____

H. Burgess

Signed.....
Student Embalmer

Licensed Embalmer No. _____

4029

P. O. Address _____

Maplewood

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.