

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25081
State File No. 6648

FILED AUG 7 1951

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1009 Registrar's No. _____

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

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1. PLACE OF DEATH a. COUNTY ST. LOUIS, MO.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE ST. LOUIS, MO. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Dr. Reed Home, Chicago		d. STREET ADDRESS (If rural, give location) 2827 DICKSON	
3. NAME OF DECEASED (Type or Print) a. (First) ORVAL		b. (Middle) NORTH CROSS	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 7 22 1951	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 11-4-1924
9. AGE (In years last birthday) 26		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) PORTER		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) MO.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME MCCOLLOUGH COOKS		13b. MOTHER'S MAIDEN NAME KATIE NORTHCROSS	
14. NAME OF HUSBAND OR WIFE SINGLE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) YES		16. SOCIAL SECURITY NO. 490-82-5125	
17. INFORMANT'S SIGNATURE OR NAME Katie Mae Northcross Latimer		ADDRESS 1957	

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* Hemothorax following gunshot wound of chest, suffered when shot with gun in the hands of one Adella Irving (Col.) in room of home at 2827 Dickson St. About 3:30 a.m. July 22nd, 1951.		INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		HOMICIDE			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? E981X	

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 **3:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Richard E. Day, Jr.		23b. ADDRESS 1300 Olive St.		23c. DATE SIGNED 7/26/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7/27/51		24c. NAME OF CEMETERY OR CREMATORY St. Louis Co. Mo.	
24d. LOCATION (City, town, or county)		25. FUNERAL DIRECTOR'S SIGNATURE Scott Johnson		ADDRESS 4352 Washington	
DATE REC'D BY LOCAL JUL 25 1951		REGISTRAR'S SIGNATURE J. B. Lasater			

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.....

Licensed Embalmer No.....

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.