

FILED SEP 13 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28148

318

1003

Registrar's No. 7739

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS (If rural, give location) 5127 Raymond Ave.	

3. NAME OF DECEASED (Type or Print)	a. (First) Sharman	b. (Middle) H.	c. (Last) Cox	4. DATE OF DEATH (Month) (Day) (Year) Aug. 30 1951
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced 3	8. DATE OF BIRTH Mar. 20 1889	9. AGE (In years last birthday) 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Salesman		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Cowden Ill	12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Harve Cox	13b. MOTHER'S MAIDEN NAME Mary Nance	14. NAME OF HUSBAND OR WIFE Nora Cox
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) W.W.I.	16. SOCIAL SECURITY NO. 526-07-5958	17. INFORMANT'S SIGNATURE OR NAME Mrs. Rose Green, 5127 Raymond Ave.

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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ACUTE MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) COLONACY THROMBOSIS		
	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"/>
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? H201

22. I hereby certify that I attended the deceased from Aug 27, 1951, to Aug. 30, 1951, that I last saw the deceased alive on Aug 30, 1951, and that death occurred at 5:05p m., from the causes and on the date stated above.

23a. SIGNATURE Robert E. Coch	(Degree or title) M.D.	23b. ADDRESS 35 N. CENTRAL, CLAYTON MO	23c. DATE SIGNED 8/31/51
24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 9/1/51	24c. NAME OF CEMETERY OR CREMATORY Decatur Ill.	24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. OFF. AUG 31 1951	REGISTRAR'S SIGNATURE Paul Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Drehmann-Harral, 1905 Union Blvd.	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Robert E. Koch,  
35 N. Central Ave.

(1 to 3)

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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.....  
*Albert R. Thompson*

Signed.....  
Student Embalmer

Licensed Embalmer No. *64237*

P. O. Address *St. Louis*

- 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.