

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH
State File No. **21874**

FILED JUL 2- 1952

318

1003

Registrar's No. **5629**

BIRTH NO.		REG. DIST. NO.		PRIMARY, REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give town)		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township)		OR TOWN <b>St. Louis</b> <b>2069</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>DePaul Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>1941A Hodiament Ave.,</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>BIRTIE</b>		b. (Middle) <b>ELIZABETH</b>		c. (Last) <b>COX.</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>June 14, 1952.</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Oct. 18, 1888</b>	
9. AGE (In years last birthday) <b>63</b>		IF UNDER 1 YEAR Months		IF UNDER 12 HRS. Days		IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country) <b>Rector, Ark., /</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>				13a. FATHER'S NAME <b>Comodor Beckley</b>		13b. MOTHER'S MAIDEN NAME <b>Amanda Palmer</b>	
14. NAME OF HUSBAND OR WIFE <b>John Cox,</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>John Cox,</b>				ADDRESS <b>1941a Hodiament Ave.,</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Renema</b>		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>NEPHROSCLEROSIS</b>				<b>1 week</b>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) <b>ARTERIOSCLEROSIS</b>				<b>YEARS</b>	
II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.		<b>HYPERTENSION AND ENLARGED HEART</b>				<b>YEARS</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>442X</b>			
22. I hereby certify that I attended the deceased from <b>6/7, 1952</b> to <b>6/14, 1952</b> that I last saw the deceased alive on <b>6/14, 1952</b> , and that death occurred at <b>6:50 P.M.</b> from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Robert A. Bauer M.D.</b>				23b. ADDRESS <b>3731 Goodfellow</b>		23c. DATE SIGNED <b>6/16/52</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>June 17, 1952</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Blooming Grove Cem.,</b>		24d. LOCATION (City, town, or county) (State) <b>Rector, Ark.,</b>	
DATE REC'D BY LOCAL REG. <b>JUN 17 1952</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Jos. W. Clark 1125 Hodiament Ave.,</b>			

(Licensed Embalmer's Statement on Reverse Side)

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

D. Robert A. Bauer  
3731 Goodfellow Blvd.,  
CO. 7302 1-4 P.M.

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 *John J. Haines*

Licensed Embalmer No. *4608*

P. O. Address *St Louis MO*

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.