

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **7454**
Registrar's No. **1412**

FILED FEB 26 1953

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) 54 years		2139	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital		d. STREET ADDRESS (If rural, give location) 13 5400 Arsenal St., St. Louis, Mo.	
3. NAME OF DECEASED (Type or Print) EDWARD		4. DATE OF DEATH January 31 1953	
a. (First)		b. (Middle) H	
c. (Last) COX		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single U	
8. DATE OF BIRTH Nov. 24, 1882		9. AGE (In years last birthday) 70	
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 (City and State or Foreign Country) Mobile, Alabama		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME J. B. Cox		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT'S SIGNATURE OR NAME Della Flora	
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.		18. MEDICAL CERTIFICATION DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial decompensation ANTECEDENT CAUSES DUE TO (b) Myocardial degeneration DUE TO (c) Generalized ASCVD 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 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR 4221		22. I hereby certify that I attended the deceased from 9-1-51 , 19__, to 1-31-53 , 19__, that I last saw the deceased alive on 1-31 , 19 53 , and that death occurred at 1:25 am. , from the causes and on the date stated above.	
23a. SIGNATURE W. A. Dale, M.D.		23b. ADDRESS 5400 Arsenal Street, St. Louis	
23c. DATE SIGNED 1-31-53		24a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE FEB-6-53		24c. NAME OF CEMETERY OR CREMATORY CALVARY	
24d. LOCATION (City, town, or county) (State) ST LOUIS MO		25. FUNERAL DIRECTOR'S SIGNATURE Charles Smith	
DATE REC'D BY LOCAL FEB 6 1953		ADDRESS 4386 Lindell	

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 Student
at College of Mortuary Science Student Embalmer No. _____
working under my personal supervision.

Student
Student Embalmer

Signed Raymond W. Hanson

Licensed Embalmer No. 3791

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.