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0.48

FILED APR 10 1953

STANDARD CERTIFICATE OF DEATH

State File No. **11410**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3341**

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| 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 OR TOWN St. Louis | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Anthony Hospital | | e. STREET ADDRESS (If rural, give location) 16 3744 Keokuk St. 2169 | |

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|-------------------------------------|---------------------------|-----------------------|--------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) William | b. (Middle) C. | c. (Last) Cox Sr. | 4. DATE OF DEATH (Month) (Day) (Year) 3/27/53 |
|-------------------------------------|---------------------------|-----------------------|--------------------------|---|

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|--------------------|-------------------------------|---|---------------------------------------|---|------------------------|----------------------|------------------------|-----------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Mar. 27, 1868 | 9. AGE (In years last birthday) 85 | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 24 HRS. Hours | IF UNDER 24 HRS. Min. |
|--------------------|-------------------------------|---|---------------------------------------|---|------------------------|----------------------|------------------------|-----------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer | 10b. KIND OF BUSINESS OR INDUSTRY -- | 11. BIRTHPLACE (City and State or Foreign Country) Indiana | 12. CITIZEN OF WHAT COUNTRY? USA |
|---|--|--|--|

| | | |
|--------------------------------------|---|--|
| 13a. FATHER'S NAME Unknown | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Caroline |
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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. --- | 17. INFORMANT'S SIGNATURE OR NAME William C. Cox Jr. | ADDRESS -3744 Keokuk |
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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, asphyxia, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident. | | INTERVAL BETWEEN ONSET AND DEATH 10 days |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio-sclerotic Heart Disease | | |
| | DUE TO (c) Hypertension | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) |
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| | | |
|--|--|---|
| 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? 4200 |
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22. I hereby certify that I attended the deceased from **Jan. 1952**, to **Mar. 27, 1953**, that I last saw the deceased alive on **Mar. 27, 1953**, and that death occurred at **2:05 a.m.**, from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) George A. O'Sullivan, M.D. | 23b. ADDRESS 421 W. Schurmer | 23c. DATE SIGNED 3-29-53 |
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|---|-----------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 3/30/53 | 24c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery | 24d. LOCATION (City, town, or county) (State) Chester, Illinois |
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|--|---|--|--------------------------------|
| DATE REC'D BY LOCAL REG. MAR 30 1953 | REGISTRAR'S SIGNATURE J. Carl Smith | 25. FUNERAL DIRECTOR'S SIGNATURE Wacker-Hellerle | ADDRESS 3634 Gravois |
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(Licensed Embalmer's Statement on Reverse Side)

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 Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Robert C. Wheeler*.....

Licensed Embalmer No. *212*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.