

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33031

FILED SEP 24 1953

State File No. \_\_\_\_\_

8018

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Louis</b>		c. LENGTH OF STAY (in this place) <b>10 days</b>		c. CITY OR TOWN <b>St Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>4865 Austria</b> <span style="float: right;">2029</span>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Walter</b>		b. (Middle) _____		c. (Last) <b>Cole</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Aug 13, 1953</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>		8. DATE OF BIRTH <b>1877</b>			
9. AGE (in years last birthday) <b>76</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>St Louis Mo.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>James Cole</b>		13b. MOTHER'S MAIDEN NAME <b>Amelia Steinmetz</b>		14. NAME OF HUSBAND OR WIFE _____			
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. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Alex Cole, 1116 South 4th St.</b> ADDRESS _____					
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.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Squamous cell carcinoma of mouth</b> ANTECEDENT CAUSES <b>tongue and throat; malnutrition; arteriosclerosis</b> DUE TO (b): _____ DUE TO (c): _____ II. OTHER SIGNIFICANT CONDITIONS <b>fracture of femur and gastrostomy - Fall at</b> Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>2 yr</b>	
19a. DATE OF OPERATION <b>about 8/9/53</b>		19b. MAJOR FINDINGS OF OPERATION <b>gastrostomy Hospital Aug 4 - 1953</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SOURCE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>St Louis 144XF</b>					
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? _____					
22. I hereby certify that I attended the deceased from <b>8-4-53</b> , 19____, to <b>8-13-53</b> , 19____, that I last saw the deceased alive on <b>8-13-53</b> , 19____, and that death occurred at <b>9:35P</b> m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>Arthur Knight Wilson M.D.</b>				23b. ADDRESS <b>539 North Grand Ave.</b>		23c. DATE SIGNED <b>8-15-53</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>8/17/53</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Hiram Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St Louis Co, Mo.</b>			
DATE REC'D BY LOCAL REG. <b>AUG 17 1953</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J L Ziegenhein &amp; Sons 7027 Gravois</b>					

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

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

Student.....  
Signature of Student Embalmer

Signed *B.P. Kidwell*.....

Licensed Embalmer No. *3877*.....

P. O. Address *7027 Graves*.....

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.