

FILED JUN 24 1954

STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **4655**

BIRTH NO. _____ 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 St. Louis	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporating town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) 0		e. STREET ADDRESS (If rural, give location) 3622 Evans	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Dan		b. (Middle) _____	c. (Last) Cole	4. DATE OF DEATH (Month) 5 (Day) 21 (Year) 54		
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 5/29/1881	9. AGE (In years last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and State or Foreign Country) Jackson, Tennessee	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Ben Cole		13b. MOTHER'S MAIDEN NAME Ida Adlock		14. NAME OF HUSBAND OR WIFE Catherine Cole	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Catherine Cole		ADDRESS 3622 Evans Avenue
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undt.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Esophagus with Metastasis		
	ANTECEDENT CAUSES Tube Fed		
II. OTHER SIGNIFICANT CONDITIONS Malnutrition; Dehydration			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____
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? 150X

22. I hereby certify that I attended the deceased from 3-23, 1954, to 5-21, 1954, that I last saw the deceased alive on 5-21, 1954, and that death occurred at 1:00 P.m., from the causes and on the date stated above.

23a. SIGNATURE Earl Belle Smith, M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 5-24-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 5/26/54	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REG. MAY 25 1954	REGISTRAR'S SIGNATURE Earl Belle Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Atkins Bros. Und. Co.	ADDRESS 3644 Finney Ave.
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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.....

John K. Cunningham

Licensed Embalmer No.....447

P. O. Address 4700 Hammett.....

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.