

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20341

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4437

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUISIS | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUISIS | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 2717 ⁹ Clark | | d. STREET ADDRESS (If rural, give location) 22 2717 ⁹ Clark | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Julia b. (Middle) Washington c. (Last) Cox | | | 4. DATE OF DEATH (Month) (Day) (Year) May 13, 1954 |
| 5. SEX 3 Female | 6. COLOR OR RACE Col | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Oct. 15, 1881 |
| 9. AGE (In years last birthday) 72 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 11. BIRTHPLACE (State or foreign country) Miss 1 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 12. CITIZEN OF WHAT COUNTRY? |
| 13a. FATHER'S NAME Jeff Jenkins | | 13b. MOTHER'S MAIDEN NAME Rosie Moore | 14. NAME OF HUSBAND OR WIFE Albert Cox |
| 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 Albert Cox 2717 ⁹ Clark |
| 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 INTERVAL BETWEEN ONSET AND DEATH 19 days | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage | | DUE TO (b) Hypertension | |
| ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | DUE TO (c) | |
| 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 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 | | 331X | |
| 22. I hereby certify that I attended the deceased from <u>Apr. 24th 1954</u> to <u>May 13th 1954</u> that I last saw the deceased alive on <u>May 13th 1954</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above. | | | |
| 23a. SIGNATURE (Degree or title) J. L. Jackson M.D. | | 23b. ADDRESS 392 ^{1/2} S. Jefferson | |
| 23c. DATE SIGNED May 14, 1954 | | | |
| 24a. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24b. DATE May 18/54 | |
| 24c. NAME OF CEMETERY OR CREMATORY Greenwood Cem. | | 24d. LOCATION (City, town, or county) (State) St. Louis MO | |
| DATE REC'D BY LOCAL REG. MAY 18 1954 | | REGISTRAR'S SIGNATURE J. Carl Smith | |
| 25. FUNERAL DIRECTOR'S SIGNATURE F. A. Green | | ADDRESS 4214 Oakman | |

(Licensed Embalmer's Statement on Reverse Side)

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

4105 Easton

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 _____

F. A. Green

Licensed Embalmer No. *2963*

P. O. Address *4214 Delmar*

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.