

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 38630

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8985

1. PLACE OF DEATH a. COUNTY <u>St. Louis - Mo</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY OR TOWN <u>St. Louis, Mo</u>		c. CITY OR TOWN <u>St. Louis (BRECKENRIDGE #237)</u>	
c. LENGTH OF STAY (in this place) <u>3 1/2 MO.</u>		d. Is Residence within limits of a city or incorporated town? <input type="checkbox"/> No <input type="checkbox"/> Yes	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis Childrens Hosp.</u>			
e. STREET ADDRESS (If rural, give location) <u>9404 St. CHARLES Park Rd.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>HELEN</u> b. (Middle) <u>IRENE</u> c. (Last) <u>COLE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>October 4 1954</u>		
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5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>		8. DATE OF BIRTH <u>August 21, 1952</u>		9. AGE (In years last birthday) <u>2 yrs. old</u>		10. IF UNDER 1 YEAR: Months _____ Days _____		10. IF UNDER 4 HRS. Hours _____ Min. _____	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis Co. Mo.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
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13a. FATHER'S NAME <u>John G. Cole</u>			13b. MOTHER'S MAIDEN NAME <u>CLARK GANN</u>			14. NAME OF HUSBAND OR WIFE _____					
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>no</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME: ADDRESS <u>F. Donahoe 5005. Kingshig.</u>							
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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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Meningitis</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hydrocephalus</u> <u>2 yrs</u> DUE TO (c) _____ 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) <u>344X</u>			
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 JUNE 14, 1954, to Oct. 4, 1954, that I last saw the deceased alive on Oct. 4, 1954, and that death occurred at 4:15 AM., from the causes and on the date stated above.

23a. SIGNATURE <u>Dr. P. Johnston</u> (Degree or title)		23b. ADDRESS <u>Childrens Hospital</u>				23c. DATE SIGNED <u>10-4-54</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>10/6/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>VALMALKER CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY MO.</u>			
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DATE REC'D BY LOCAL REGISTERAR'S SIGNATURE <u>J. Carl Smith - MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Callie Mortuary 10123 St. Char. Rd.</u>					
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OCT 4 1954

(Licensed Embalmer's Statement on Reverse Side)

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 *Sheldon Collier*

Licensed Embalmer No. *338*

P. O. Address *1012381*

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.