

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **13208**  
**3852**

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

|  |                               |   |   |
|--|-------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>MO</b> b. COUNTY  |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST LOUIS, MO</b>   |                               | c. LENGTH OF STAY (in this place)   | c. CITY OR TOWN <b>ST LOUIS</b>   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>MISSOURI PACIFIC HOSP.</b>  |                               | e. STREET ADDRESS (If rural, give location) <b>4173 CLAY AV.</b>  |   |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>SETH</b> b. (Middle) <b>WALLACE</b> c. (Last) <b>COBB</b>   |                               | 4. DATE OF DEATH (Month) (Day) (Year) <b>APRIL 29 1955</b>  |   |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>   | 8. DATE OF BIRTH <b>DEC. 20, 1900</b>                                       |
| 9. AGE (In years last birthday) <b>54</b>  |                               | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>YARD CLERK</b>  | 11. BIRTHPLACE (City and State or Foreign Country) <b>ST LOUIS MISSOURI</b> |
| 10b. KIND OF BUSINESS OR INDUSTRY <b>TERMINAL RR</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   |
| 13a. FATHER'S NAME <b>CHARLES COBB</b>   |                               | 13b. MOTHER'S MAIDEN NAME <b>LEONORA WHITE</b>  | 14. NAME OF HUSBAND OR WIFE <b>BERNICE</b>                                  |
| 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>BERNICE COBB</b>  |                               | ADDRESS <b>4173 CLAY AVE</b>  |   |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.                               |                               | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Cardiac Failure</b><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Unusual Arteriosclerosis</b><br>DUE TO (c) <b>Senility (early)</b><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Unway theobis Present</b> |   |
| 19a. DATE OF OPERATION   |                               | 19b. MAJOR FINDINGS OF OPERATION  |   |
| 20. AUTOPSY? YES <input checked="" 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? <b>4201</b>   |                               |   |   |
| 22. I hereby certify that I attended the deceased from <b>Nov</b> , 1954, to <b>April</b> , 1955, that I last saw the deceased alive on <b>April 29</b> , 1955, and that death occurred at <b>12:45 A.M.</b> , from the causes and on the date stated above. |                               |   |   |
| 23a. SIGNATURE <b>Her Boyd</b>   |                               | 23b. ADDRESS <b>ms Pac loop</b>   |   |
| 23c. DATE SIGNED <b>4-29-55</b>  |                               |   |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |                               | 24b. DATE <b>5/2/55</b>   |   |
| 24c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>   |                               | 24d. LOCATION (City, town, or county) (State) <b>ST LOUIS MISSOURI</b>  |   |
| DATE REC'D BY LOCAL REG. <b>APR 30 1955</b>  |                               | REGISTRAR'S SIGNATURE <b>J. Carl Smith md</b>   |   |
| 25. FUNERAL DIRECTOR'S SIGNATURE <b>STROOT - CARROLL</b>   |                               | ADDRESS <b>4600 NATURAL BRIDGE AVE</b>  |   |

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 *M W Ruter*

Licensed Embalmer No. *48*

P. O. Address *St Louis*

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.