

FILED SEP 29 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 30716

BIRTH NO. 5944-55 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8318

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>26 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>Homer G. Phillips</b>				STREET ADDRESS (If rural, give location) <b>21 2209 Market</b>			
3. NAME OF DECEASED (Type or Print) a. (First)		b. (Middle)		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) <b>Cox 8 29 55</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>8-3-55</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <b>26</b>	
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) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME <b>Marion Cox</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)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <i>William M. Sherard</i>		ADDRESS <b>CR 2601N. Whittier</b>	
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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Bronchopneumonia</b>				MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 <b>763.0</b>				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?			
22. I hereby certify that I attended the deceased from <b>8-3-</b> , 19 <b>55</b> , to <b>8-28-</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>8-28-</b> , 19 <b>55</b> , and that death occurred at <b>12:50pm.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <i>William M. Sherard</i>				(Degree or title) <b>M. D.</b>		23b. ADDRESS <b>2601N. Whittier</b>	
23c. DATE SIGNED <b>9-9-55</b>		24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>9-30-55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>	
24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Carl Smith</i>		ADDRESS <b>4104 Manchester Ave.</b>			
DATE REC'D BY LOCAL REG. <b>SEP 22 1955</b>		REGISTRAR'S SIGNATURE <i>Carl Smith</i>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Howland Aker Mortuary Service</b>			

(Licensed Embalmer's Statement on Reverse of This Certificate)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.