

No. 300
10-48

FILED DEC 12 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38105**
Registrar's No. **10592**

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 **Mo.** b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) **St. Louis** c. LENGTH OF STAY (In this place) **30 years**
c. CITY OR TOWN **St. Louis** d. Is Residence within limits of a city or incorporated town? Yes No
d. FULL NAME OF HOSPITAL OR INSTITUTION **Homer G. Phillip Hospital** STREET ADDRESS (If rural, give location) **2023rd Eugenia**

3. NAME OF DECEASED (Type or Print) **Catholica** a. (First) _____ b. (Middle) _____ c. (Last) **Cobbs**
4. DATE OF DEATH (Month) (Day) (Year) **12 1 55**

5. SEX **Female** b. COLOR OR RACE **Colored** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Single** 8. DATE OF BIRTH **July 18th 1909** 9. AGE (In years last birthday) **46** UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **General work** 10b. KIND OF BUSINESS OR INDUSTRY **NONE** 11. BIRTHPLACE (City and State Foreign Country) **Marianna, Arkansas** 12. CITIZEN OF WHAT COUNTRY? **U.S.**

13a. FATHER'S NAME **P** 13b. MOTHER'S MAIDEN NAME **Louise Slattery** 14. NAME OF HUSBAND OR WIFE **NONE**

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 **Velma Cobbs** ADDRESS **2023rd Eugenia**

18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c) _____
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Carcinoma of Esophagus.** (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 **150x** 20. AUTOPSY? YES NO

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) (Minute) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **1035th m.**, from the causes and on the date stated above.

23a. SIGNATURE **James M Kelly** (Registrar's Title) **Registrar** 23b. ADDRESS **1300 Clark** 23c. DATE SIGNED **12-3-55**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24b. DATE **12-9-55** 24c. NAME OF CEMETERY OR CREMATORY **Greenwood** 24d. LOCATION (City, town, or county) (State) **St. Louis, Mo.**

DATE REC'D BY LOCAL REG. **DEC 3 1955** REGISTRAR'S SIGNATURE **J. Carl Smith** FUNERAL DIRECTOR'S SIGNATURE **McPinkie L. Toney** ADDRESS **3129 Race**

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 *James B. Carter*.....
Licensed Embalmer No. *46*
P. O. Address *J. B. Carter*.....

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.