

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File # **85394**
Registrar's No. **9834**

FILED NOV 16 1956

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 town) **ST. LOUIS**

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 PHILLIPS**

• STREET ADDRESS (If rural, give location)
2010 1617 LEFFINGWELL

3. NAME OF DECEASED
a. (First) **ZEOLA**

b. (Middle) _____ c. (Last) **COTTON**

4. DATE OF DEATH (Month) (Day) (Year)
OCT. 26, 1956

5. SEX
FEMALE

6. COLOR OR RACE
NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
NOT MARRIED

8. DATE OF BIRTH
AUG. 9, 1935

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
1

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE

10b. KIND OF BUSINESS OR INDUSTRY
—

11. BIRTHPLACE (City and State or Foreign Country) **ST. LOUIS, MO**

12. CITIZEN OF WHAT COUNTRY?
USA

13a. FATHER'S NAME
MOSE VASSER

13b. MOTHER'S MAIDEN NAME
TRYPHENE BOOTIE

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)
NO

16. SOCIAL SECURITY NO.
NONE

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
TRYPHENE COTTON 1617 LEFFINGWELL

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, assthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____

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.
Branches Pleuro pneumonia

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION
491x

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)

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 _____, 1956 to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **3:00 m., from the causes and on the date stated above.**

23a. SIGNATURE (Name or title)
Joseph E. [Signature] Deputy Registrar

23b. ADDRESS
1300 CLARK AVE.

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL

24b. DATE
10-31-56

24c. NAME OF CEMETERY OR CREMATORY
WASHINGTON PARK

24d. LOCATION (City, town, or county) (State)
ST. LOUIS COUNTY MO.

DATE REC'D BY LOCAL REG.
OCT 29 1956

REGISTRAR'S SIGNATURE
Carl Smith MO

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
MCCAIN-BANNISTER 4251 WASHINGTON

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 *Leroy H. Garrison*.....

Licensed Embalmer No. *4523*.....

P. O. Address *2616 Garrison*.....

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.