

health, Welfare Public service  
 300 1-56  
 All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
 Doctor, Coroner, etc. must use only standard nomenclature in item 10. No symptoms with be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED MAY 31 1957

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

18559  
 STATE FILE NUMBER 4626

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6411 Lindenwood Ave.			Length of stay in lb 4 yrs.		d. STREET ADDRESS 6411 Lindenwood Ave.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rose Middle C. Last Cox				4. DATE OF DEATH Month May Day 13 Year 1957				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 17, 1895		9. AGE (In years last birthday) 62 IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William A. Kasten				14. MOTHER'S MAIDEN NAME Rose Reifeiss				
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 Address Charles M. Cox 6411 Lindenwood Ave.				
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Suffocation by Hanging;</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>E974x</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Suffered when alone in garage</i> <i>suicided self in garage</i> <i>in fear of poison for May 13th 1957 while suffering from temporary mental aberration</i>							INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input checked="" type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Early parts of injury in Part I or Part II of report) <i>in fear of poison for May 13th 1957 while suffering from temporary mental aberration</i>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m. <i>5 13 57</i>		20d. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.) <i>14 Home</i>		20e. CITY, TOWN OR LOCATION <i>St Louis Mo.</i>		20f. COUNTY <i>St Louis Mo.</i>		STATE
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <i>5:35 P.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>Patrick J. Taylor Coroner</i>				22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>5.15.57</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>May 16, 1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Sunset Burial Park</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis County, Mo.</i>			
24. FUNERAL DIRECTOR <i>Holmeister Colonial Mortuary</i> <i>6464 Chippewa St., St. Louis, Mo.</i>			25. DATE RECD. BY LOCAL REG. <i>MAY 15 '57</i>		26. REGISTRAR'S SIGNATURE <i>J. Earl Smith, M.D.</i> <i>S.P.</i>			

(Licensed Embalmer's Statement on Reverse Side)

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 *Bill C. Brown*

Licensed Embalmer No. *47*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.