

FILED NOV 19 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41859
STATE FILE NUMBER 1003
10081
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

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 type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 822 Lafayette			Length of stay in lb 10 Yrs.		STREET ADDRESS 822 Lafayette		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First IDA Middle JOSEPHINE Last COOL			4. DATE OF DEATH Month 11-7-1957 Day Year				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-23-1908	9. AGE (In years last birthday) 49		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 Own Home		11. BIRTHPLACE (City and state or country) Bowling Green, Ky.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Iler				14. MOTHER'S MAIDEN NAME Unobtainable			
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 William Cool, 822 Lafayette			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Essential Hypertension Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arterial Sclerosis with DUE TO (c) Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)							INTERVAL BETWEEN ONSET AND DEATH 8 yrs
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 443A				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21. I attended the deceased from 1-19-49 to 11-7-57 and last saw her alive on 9-11-57 Death occurred at 11-7-57 m on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE Royal A. Owen M.D.				22b. ADDRESS 442 N. TAYLOR		22c. DATE SIGNED 11/8/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11-9-1957	23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) (State) Staunton, Illinois		
24. FUNERAL DIRECTOR McLAUGHLIN'S, 2301 Lafayette			25. DATE RECD. BY LOCAL REG. NOV 9 57		26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.		

Dr Weir
462 N Taylor

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 *H. G. Farris*.....

Licensed Embalmer No. *338*

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.