

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023215
STATE FILE NUMBER

FILED JUL 14 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6793

300
1-57

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis 12 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Res. 5876 Cates		Length of stay in 1b 12yrs 2 1/2	d. STREET ADDRESS (If outside, give location) 5876 Cates Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last EUNICE AGNES COX			4. DATE OF DEATH Month Day Year July 6, 1958	
---	--	--	---	--

5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30, 1872	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. 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 Home	11. BIRTHPLACE (City and state or country) Baldwin, Ill.	12. CITIZEN OF WHAT COUNTRY? USA
---	--	--	--

13a. FATHER'S NAME James Redpath Holden	13b. MOTHER'S MAIDEN NAME Sarah Johnson	14. NAME OF HUSBAND OR WIFE John Edwin Cox
---	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None	16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. Thelma C. Powell 5876 Cates
---	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction - progressive		INTERVAL BETWEEN ONSET AND DEATH 1yr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Adeno-carcinoma ascending colon resection Nov. 1955	
	DUE TO (c) 153.0	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertensive Arteriosclerotic Heart Disease Burns Plus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.)
---	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	---	---	---

21. I attended the deceased from 1950 to July 6, 1958 and last saw ^{her} alive on July 5, 1958 Death occurred at 12:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) J. Redpath Holden M.D.	22b. ADDRESS 864 Hamilton Blvd St. Louis 12 Mo.	22c. DATE SIGNED 7-7-58
---	---	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE July 8, 1958	23c. NAME OF CEMETERY OR CREMATORY Baldwin Cemetery	23d. LOCATION (City, town, or county) (State) Baldwin, Ill.
---	----------------------------------	---	---

24. FUNERAL DIRECTOR ALEXANDER & SONS	ADDRESS 6175 DELMAR	25. DATE RECD. BY LOCAL REG. JUL 8 '58	26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D.
---	-------------------------------	--	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

J. Earl Smith, M.D.
M. J. B.

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 *Jos. E. McCulloch*

Licensed Embalmer No. *2760*

P. O. Address *6175 Illinois*

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.