

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-037688  
State File No. 10409

FILED NOV 10 1958

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place) 17 yrs	
d. FULL NAME OF HOSPITAL OR INSTITUTION 01 2329 Chestnut St.		e. STREET ADDRESS (If rural, give location) 229 2329 Chestnut St.	
3. NAME OF DECEASED (Type or Print) a. (First) Lula b. (Middle) T. c. (Last) Cole		4. DATE OF DEATH (Month) (Day) (Year) Oct 28, 1958	
5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 1	8. DATE OF BIRTH Oct 26, 1879
9. AGE (In years last birthday) 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (City and State or Foreign Country) Blythville, Ark. 1		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
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 Beatrice Garrett-804 W. Madison	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) = myocardial infarction hypertension hypertension hypertension 420.1 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	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from Aug 1, 1958, to Oct 28, 1958, that I last saw the deceased alive on Oct 28, 1958, and that death occurred at 4 P.M., from the causes and on the date stated above.	
23a. SIGNATURE Walter A. Younge (Degree or title) Walter A. Younge M.D.		23b. ADDRESS 4635 Easton 4635 Easton	
23c. DATE SIGNED 10/30/58		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE Nov. 1-1958		24c. NAME OF CEMETERY OR CREMATORY Booker Washington	
24d. LOCATION (City, town, or county) (State) East St. Louis, Ill.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Marshall Funeral Home-E. St. Louis, Ill.	
DATE REC'D BY LOCAL REG. OCT 30 58		REGISTRAR'S SIGNATURE E. Carl Smith M.D. S.P.	

**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 *Thomas M. Habern*.....

Licensed Embalmer No. 4479.....

P. O. Address E. 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.