

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-045530

STATE FILE NUMBER

12557

FILED JAN 12 1959

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

300  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL #1. 55</b>		Length of stay in lbs <b>1. 55</b> yrs	d. STREET ADDRESS (If outside, give location) <b>6718 Clayton</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>ALFRED</b> Middle <b>SAMUEL</b> Last <b>COTE</b>			4. DATE OF DEATH Month <b>12</b> Day <b>26</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 24, 1870</b>	9. AGE (In years last birthday) <b>88</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Theatre Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Moving Pictures</b>	11. BIRTHPLACE (City and state or country) <b>Joliet, Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>Ely Cote</b>		13b. MOTHER'S MAIDEN NAME <b>Susan (unknown)</b>		14. NAME OF HUSBAND OR WIFE <b>Mabel Brand Cote</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>491-14-4565</b>	17. INFORMANT Address <b>Muriel E. Cote, 6718 Clayton</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>One day</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Chronic Brain Syndrome</b>	<b>unknown</b>
	DUE TO (c) <b>Generalized arteriosclerosis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>450.0</b>		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 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 **12-15-1958** to **12-26-1958** and last saw her alive on **12-26-1958**  
Death occurred at **3:50 P.M.** m on the date stated above; and to the best of my knowledge, from the causes stated.

21a. SIGNATURE (Degree or title) <b>W. O. Mulligan M.D.</b>	22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	22c. DATE SIGNED <b>12-26-1958</b>
--	--	---------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/29/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
--	------------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS <b>Alexander &amp; Sons, 6175 Delmar</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 29 '58</b>	26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>
--	---	---

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

02007 .13

RECEIVED BY THE BOARD

02007 - 05 - 01

02007

.0

02007

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

02007-05-01

02007-05-01

Signed

*Gustav W. Dietz*

02007-05-01

Licensed Embalmer No. 4329

P. O. Address St. Louis Mo

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.