

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007008

STATE FILE NUMBER

2 1737

FILED MAR 10 1959

Registration District No.

Primary Registration District No.

Registrar No.

300

-57

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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 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 Homer Phillips Hospital		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 2617 Franklin (rear)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Joe Middle (Luther Maufas) Last Cox (also known as)			4. DATE OF DEATH Month 2 Day 15 Year 1959		
5. SEX Male	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 Sept. 24, 1869		9. AGE (In years) 89 (at birthday) IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY unemployed	11. BIRTHPLACE (City and state or country) Pinebluff Ark. /		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Luther Maufas		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Ellen Cox	
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. unknown	17. INFORMANT Address Alice Mitchell 2433 Ofallon Apt. 606		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Left Hip. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Generalized Arteriosclerosis DUE TO (c) 903.020					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) Suffered in fall to floor at home				
20c. TIME OF INJURY Hour 2 25 a.m. February 2 1959 p.m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or out of home, farm, school, street, office bldg., etc.) 213 North	20f. CITY, TOWN, OR LOCATION St. Louis Mo		COUNTY	STATE
21. I attended the deceased from 1028 A to her and last saw him alive on m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Joseph M. [Signature]			22b. ADDRESS 1300 Clark		22c. DATE SIGNED 2/16/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2/20/59	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d. LOCATION (City, town, or county) (State) Lemay, Mo.	
24. FUNERAL DIRECTOR Atkins Bros.		ADDRESS 3644 Finney Ave.		25. DATE RECD. BY LOCAL REG. FEB 18 '59	26. REGISTRAR'S SIGNATURE Robert Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *John K. Cunningham*
Licensed Embalmer No. *4476*
P. O. Address *2405*

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.