

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010819

STATE FILE NUMBER

2377

HEALTH, Welfare, Public Service

300  
-57

FILED MAR 25 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Missouri</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Baptist Hosp.</u>		Length of stay in lb <u>4 weeks</u>	d. STREET ADDRESS (If outside, give location) <u>3757 Westminister</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Lillian Cox</u>			4. DATE OF DEATH Month Day Year <u>Feb. 22, 1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 14, 1888</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY <u>Sewing</u>	9. AGE (In years last birthday) <u>70</u> IF UNDER 1 YEAR Months Days <u>4 8</u> IF UNDER 24 HRS. Hours Min.
10a. FATHER'S NAME <u>William Sumner Cox</u>		10b. MOTHER'S MAIDEN NAME <u>Mary Emma Marmaduke</u>	10c. NAME OF HUSBAND OR WIFE <u>None</u>
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		11. SOCIAL SECURITY NO. <u>488-03-2888</u>	11. INFORMANT Address <u>Henrietta Cox 3757 Westminister St. Louis</u>
12. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertensive vascular disease</u> DUE TO (c) <u>331x</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			12. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
13a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		13b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
14c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
14d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		14e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	14f. CITY, TOWN, OR LOCATION COUNTY STATE
15. I attended the deceased from <u>1-24-59</u> to <u>2-22-59</u> and last saw <sup>her</sup> / <sub>him</sub> alive on <u>2-22-59</u> Death occurred at <u>9:05 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
16a. SIGNATURE (Degree or title) <u>Henry F. Bergman M.D.</u>		16b. ADDRESS <u>3720 Washington</u>	16c. DATE SIGNED <u>3/2/59</u>
17a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	17b. DATE <u>Feb. 25, 1959</u>	17c. NAME OF CEMETERY OR CREMATORY <u>Star Hope Cemetery</u>	17d. LOCATION (City, town, or county) (State) <u>Elsberry Lincoln Missouri</u>
18. FUNERAL DIRECTOR ADDRESS <u>Clifton Miller Elsberry, Missouri</u>		19. DATE RECD. BY LOCAL REG. <u>MAR 9 '59</u>	20. REGISTRAR'S SIGNATURE <u>Earl Smith M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in their reports - symptoms when related. 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 *Clifton Miller* .....

Licensed Embalmer No. *3364* .....

P. O. Address *Elkhart, 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.