Health, Welfare Public Service

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1-57

FILED MAY 6 1959

EX XC 2370103
SL 19287

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-014835
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 3847

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY MADISON
b. CITY OR TOWN ST. LOUIS — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN COLLINSVILLE — Inside Limits Yes [ ] No [X]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) VET. ADM. HOSPITAL — Length of stay in 1b: 46 DAYS	d. STREET ADDRESS (If outside, give location) P.O.BOX 494 — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: CHARLES	Middle: H	Last: COX	4. DATE OF DEATH Month Day Year: 4-19-59		
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	8. DATE OF BIRTH: 6-4-77	9. AGE (In years on last birthday): 81	IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country): JACKSONVILLE ILLINOIS	12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME: JERRY COX	13b. MOTHER'S MAIDEN NAME: ISABELLE MC FILLEN	14. NAME OF HUSBAND OR WIFE: DECEASED			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): SPAW	16. SOCIAL SECURITY NO.: 500-16-0363	17. INFORMANT: VA HOSP RECORDS	Address: 915 N GRAND ST LOUIS MO		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) INTRACEREBELLAR HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: MINUTES

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) GENERALIZED ATHEROSCLEROSIS — YEARS

DUE TO (c) 331 + A

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): TUBERCULOSIS PULMONARY LEFT UPER LOBE ABSCESS

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. VA attended the deceased from 3-4-59, to 4-19-59 and last saw him alive on 4-19-59

Death occurred at 8:00 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: James Young	(Degree or title): JAMES YOUNG M. D.	22b. ADDRESS: VAH. ST. LOUIS, MO.	22c. DATE SIGNED: 4-19-59
23a. BURIAL, CREMATION, REMOVAL (Specify):	23b. DATE: 4/22/59	23c. NAME OF CEMETERY OR CREMATORY: East Cemetery	23d. LOCATION (City, town, or county): Jacksonville, (State): Illinois
24. FUNERAL DIRECTOR: C. R. Lupton & sons	ADDRESS: 7233 Delmar Blvd	25. DATE RECD. BY LOCAL REG.: APR 20 '59	26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Arnold W. Schoene

Licensed Embalmer No. 3864

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.