

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014836

STATE FILE NUMBER

FILED APR 24 1959

Registration District No. _____ Primary Registration District No. _____ Registration No. **3411**

5. 300
1-57
3
792
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 4105 Flad Ave.	
3. NAME OF DECEASED (Type or print) First HOWARD Middle PRESLEY Last COX			4. DATE OF DEATH Month APRIL Day 4 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 Oct. 27, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if voluntary) Food Trucker (Retired)		10b. KIND OF BUSINESS OR INDUSTRY State Hospital	11. BIRTHPLACE (City and state or country) Baldwin, Ill.
13a. FATHER'S NAME Presley Cox		13b. MOTHER'S MAIDEN NAME Sarah Irene Wiggenton	14. NAME OF HUSBAND OR WIFE Virginia Cox
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 488-01-0445	17. INFORMANT Address Virginia Cox 4105 Flad Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction			INTERVAL BETWEEN ONSET AND DEATH 5 min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hypertensive Cardiovascular Disease			15 yrs.
DUE TO (c) 420.1			
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 checked="" type="checkbox"/> NO <input 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 WORK <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 3/20/58 , to 4/4/59 and last saw ^{her} _{him} live on 4/4/59 Death occurred at 11:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE R. V. Bradley M.D.		22b. ADDRESS BARNES HOSPITAL	
22c. DATE SIGNED 4/5/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Apr. 8, 1959	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway		25. DATE RECD. BY LOCAL REG. APR 6 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Richard W. Storrsand*

Licensed Embalmer No. *4007*

P. O. Address

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.