

**MRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-003258**

**FILED 13 FEB 10 1960**

STATE FILE NUMBER

Registration-District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2-1200**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Alexian Bros. Hosp.</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <b>4115a Botanical Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>ARCHIE</b> Middle <b>S.</b> Last <b>COHEA</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>1</b> Year <b>1960</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>7-19-1868</b>		9. AGE (last birthday) <b>91</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer (Retired) Self</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Employed</b>		11. BIRTHPLACE (City and state or country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>Unknown Cohea</b>				13b. MOTHER'S MAIDEN NAME <b>Unknown</b>				14. NAME OF HUSBAND OR WIFE <b>Late Effie Cohea</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>None</b>		17. INFORMANT Address <b>cal</b> <b>Cleveland H. Cohea 4115a Botanie</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <b>cerebral hemorrhage</b>										<b>1 wk</b>			
DUE TO (b) <b>circulatory disease</b>										<b>(3)</b>			
DUE TO (c) <b>Senility age 91</b>										<b>(?)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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.		Month, Day, Year											
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 <b>Jan 28 '60</b> to <b>Feb 1 '60</b> and last saw her <b>Jan 30 '60</b> and last saw him <b>Jan 30 '60</b> Death occurred at <b>8:45 A.</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <b>W.H. Clithero M.D.</b>						22b. ADDRESS <b>906 Carleton Bldg.</b>			22c. DATE SIGNED <b>2-2-60</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Feb. 4, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>			23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>						
24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S. Kingshighway</b>				25. DATE RECD. BY LOCAL REG. <b>FEB 2 1960</b>		26. REGISTRAR'S SIGNATURE <b>Loal Smith M.D.</b>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*William B. White*

Licensed Embalmer No. 4281

P. O. Address 4228 King

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.