

REC'D OCT 11 1939 791  
Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH: 1003  
(a) County ST. LOUIS, CITY OF  
(b) City or town ST. LOUIS  
(c) Name of hospital or institution: MISSOURI PACIFIC HOSP  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days \_\_\_\_\_

3. (a) PRINT FULL NAME IRVING AUSTIN COTTON  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. 702-18-4574

4. Sex M 5. Color or race W  
6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife ESTELLE COTTON  
6. (c) Age of husband or wife if alive 52 years  
7. Birth date of deceased SEPT 21 1885  
(Month) (Day) (Year)

8. AGE: Years 54 Months - Days -  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation ENGINEER 5

11. Industry or business RAILROAD 7

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature ESTELLE COTTON

(b) Address COFFEYVILLE KANSAS

17. (a) REMOVAL (b) Date thereof 9-23-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation COFFEYVILLE, KANSAS

18. (a) Signature of funeral director ALBERT H NOPPE

(b) Address 4700 WASHINGTON

19. (a) SEP 21 1939 (b) \_\_\_\_\_  
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State KANSAS (b) County 2  
(c) City or town COFFEYVILLE NR.  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept. day 21  
year 1939 hour 8:00 minute 40 AM.  
21. I hereby certify that I attended the deceased from 9-19, 1939, to 9-21, 1939  
that I last saw him alive on 9-20-39, 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute coronary thrombosis  
Due to Cardiac Hypertrophy  
Due to Chronic Myocarditis  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: MI  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? 1 (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature Geall. Blankenship (M. D. or other) \_\_\_\_\_  
Address 1755 S. Ward Date signed 9-21-39

WHITE LABEL—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1-10951

11  
M  
KID  
REPORT  
1944

NOV 1 1944

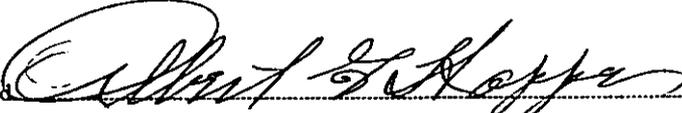
---

---

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed 

Licensed Embalmer No. 2971

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 this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

31078  
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. 791  
(b) Township St Louis Primary Registration District No. 1003  
(c) City St Louis (d) Street No. .... Registered No. 8141  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Irving Austin Cotton  
(a) Residence, No. .... St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
35 4 - -

OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

FATHER  
13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER  
15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 1939

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 12-15 1939 J. F. Bredeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-21-39

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h. .... alive on ..... 19..... Death is said

to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury..... 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify

(Signed) Geo W Blankensly M. D.

(Address) Grand

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED IN REG. #. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

