

S. No. 2
DM-5-43
v. 5-17-39
X36671

4106

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **1341**

FILED FEB 23 1945

Registration District No. _____ Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Johns Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 30 Years
years, months or days)

3. (a) PRINT FULL NAME Olive Cox
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced, Widow
 6. (b) Name of husband or wife Walter W. Cox
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Feb. 10 1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 0 0 hr. min.

9. Birthplace New York New York
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER

12. Name Charles Knight
 13. Birthplace New York New York
(City, town, or county) (State or foreign country)
 14. Maiden name Catherine Doyle
 15. Birthplace New York New York
(City, town, or county) (State or foreign country)

16. (a) Informant Ted Cox
 (b) Address 6212 Alamo Ave

17. (a) Burial (b) Date thereof 2-13-45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly
 (b) Address 3840 Lindell Blvd

19. (a) FEB 11 1945 (b) J. J. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
 (c) City or town Clayton
(If outside city or town limits, write "RURAL")
 (d) Street No. 6212 Alamo Ave.
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 10
 year 1945 hour 8 minute 15 A.M.
 21. I hereby certify that I attended the deceased from 12-26-44 to 2-10-45
 that I last saw her alive on 2-9-45
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cerebral Thrombosis
 Due to Arterio Sclerotic
 Due to Diabetes Mellitus
 Other conditions _____
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
 Of operations _____
 Of autopsy _____

Underline the cause to which death should be charged statistically.

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? _____
(Specify type of place) (Means of injury)
 23. Signature [Signature] (M. D. optional)
 Address [Signature] Date signed 2-10-45

*Dr. Carl Reis
Hennepin Co. Pa.*

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 *Stanley Marshall*

Licensed Embalmer No. *2868th*

P. O. Address *3840 Hindell*

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, fact should be so stated above.