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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 11113

Registration District No. 818 Primary Registration District No. 1003 Registrar's No. 3571

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

**1. PLACE OF DEATH:**

(a) County

(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Five Month (Specify whether
In this community Six years
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County 000

(c) City or town St Louis 1720
(If outside city or town limits, write "RURAL")

(d) Street No. 1526 N. Garrison
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Asa Cotledge

3. (b) If veteran, name war #1

3. (c) Social Security No. 709-12-4109

4. Sex Male 9

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Etter

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased Aug (Month) 14 (Day) 1894 (Year)

8. AGE: Years 50 Months 8 Days 5 If less than one day ___ hr. ___ min.

9. Birthplace Arkadelphia (City, town, or county) Ark 1 (State or foreign country)

10. Usual occupation Pullman Porter

11. Industry or business

FATHER
12. Name Millie Cotledge
13. Birthplace (City, town, or county) Ark. 1 (State or foreign country)

MOTHER
14. Maiden name Mollie Carter
15. Birthplace Helena (City, town, or county) Ark. 1 (State or foreign country)

16. (a) Informant Etter Cotledge
(b) Address 1526 N. Garrison Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-23-45 (Month) (Day) (Year)
(c) Place: burial or cremation National Cem.

18. (a) Signature of funeral director Porter's
(b) Address 3028 Dickson St.

19. (a) APR 23 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 19 year 1945 hour 6 minute 08 M.

21. I hereby certify that I attended the deceased from ___, 19___, to ___, 19___;
that I last saw h___ alive on ___, 19___;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion Luetic Aortitis

Due to

Due to 30

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

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?
(Specify type of place)

While at work? (e) Means of injury 3

23. Signature Alfred Perry (M. D. or other)

Address Lipa Stoon Date signed 4/23/45

(Licensed Embalmer's Statement on Reverse Side)

## 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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

**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.**