

V. S. No. 2  
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DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS  
 THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
 Registrar's No. **4384**

Registration District No. **318** 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:  
Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 8 days  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1122 A N 22nd St  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Maria Cole  
**3. (b) If veteran,** name war \_\_\_\_\_ **3. (c) Social Security** No. \_\_\_\_\_  
**4. Sex** Female **5. Color** Cole  
**6. (a) Single, widowed, married,** Married  
 divorced \_\_\_\_\_  
**6. (b) Name of husband or wife** Will Cole **6. (c) Age of husband or wife if**  
 alive 70 years  
**7. Birth date of deceased** Dec 22, 1875  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month May day 10  
 year 1946 hour 6 minute 45 P. M.  
**21. I hereby certify that I attended the deceased from** May 2, 1946 to May 10, 1946  
 that I last saw h. er alive on May 10, 1946  
 and that death occurred on the date and hour stated above.

**8. AGE:**

Years	Months	Days	If less than one day
<u>70</u>	<u>4</u>	<u>18</u>	_____ hr. _____ min.

Immediate cause of death \_\_\_\_\_  
Hypertensive Heart Disease  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

**9. Birthplace** St Louis MO  
(City, town, or county) (State or foreign country)  
**10. Usual occupation** House Wife

Other conditions Coronary Occlusion  
(Include pregnancy within 3 months of death)

MOTHER FATHER

**11. Industry or business** \_\_\_\_\_  
**12. Name** Elych Wilson  
**13. Birthplace** Mo  
(City, town, or county) (State or foreign country)  
**14. Maiden name** Elizabeth Wilson  
(City, town, or county) (State or foreign country)  
**15. Birthplace** Baltimore Maryland  
(City, town, or county) (State or foreign country)

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

**16. (a) Informant** Elizabeth Hutcherson  
**(b) Address** 4013 Aldine St  
**17. (a) Burial **(b) Date thereof** May 11, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** St. Peters Cem**

**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? \_\_\_\_\_

**18. (a) Signature of funeral director** J. A. Green  
**(b) Address** 2710 Franklin Ave  
**19. (a) MAY 15 1946 **(b) J. F. Bredees**  
(Date received local registrar) (Registrar's signature)**

While at work? \_\_\_\_\_  
(Specify type of place) (c) Means of injury  
**23. Signature** Orison J. Weyer (M. D. or other)  
**Address** 2601 N. Whittier Date signed 5/10/46

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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 F. A. Green

Licensed Embalmer No. 2463

P. O. Address. 2915 Franklin

**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.**