

No. 2  
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17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED FEB 10 1947**  
918

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

2347  
State File No. \_\_\_\_\_  
Registrar's No. **965**

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

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town **St. Louis, Missouri**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**St. Louis City Hospital-Max C. Starkloff**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether **Memorial**)  
In this community \_\_\_\_\_  
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. **4257 McPherson**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Alsey Cokoris**  
3. (b) If veteran, name war **No**  
3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Widow**  
6. (b) Name of husband or wife **Alex Cokoris**  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **May 31 1888**  
(Month) (Day) (Year)

8. AGE: Years Months Days  
**58 7 26**  
If less than one day  
hr. min.

9. Birthplace **Bismarck Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name **Elias Bestlinghoff**  
13. Birthplace **Germany**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Mattie Horn**  
15. Birthplace **Tenn.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Alsey Hosey**  
(b) Address **2612 N. Robinson St., Okla. City, Okla.**

17. (a) **Burial** (b) Date thereof **1-29-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cemetery**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Blvd.**

19. (a) **JAN 28 1947** (b) **J. F. Budick**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Jan.** day **27th**  
year **1947** hour **12:25** minute **P** M.  
21. I hereby certify that I attended the deceased from **12/21/46**  
to **1/27/47**, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw **her** alive on **1/27/47**, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinomatous due to Carcinoma of stomach**  
Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy **Gen'l carcinomatous ca. of stomach**  
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 \_\_\_\_\_

23. Signature **1515 Lafayette** **1/27/47**  
(City or town) (State) (Date)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

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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

*J. Allen Davis Jr.*

Licensed Embalmer No. *4053*

P. O. Address *H. Davis*

**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.**