S. No. 2
M—12-45
v. 5-17-39
I X47070

Dr Kohn Kalish

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 5 1947

Registration District No. 377

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 3492

Registrar's No. 218

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Koch (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Koch Hospital O (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 177 Days (Specify whether years, months or days)
In this community 177 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 17 (If outside city or town limits, write "RURAL")
(d) Street No. 2939 Easton 9 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country —

3. (a) PRINT FULL NAME Jeff Cotton
3. (b) If veteran, name war No
3. (c) Social Security No. 496-12-7720
4. Sex Male 2
5. Color or race Negro
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary J. Cotton
6. (c) Age of husband or wife if alive ? years
7. Birth date of deceased 6 (Month) 10 (Day) 14 (Year)

8. AGE: Years 32 Months 7 Days 14 If less than one day ___ hr. ___ min.

9. Birthplace Macon (City, town, or county) Miss 1 (State or foreign country)
10. Usual occupation Laborer
11. Industry or business —
FATHER
12. Name Jeff Cotton
13. Birthplace — (City, town, or county) Miss. 1 (State or foreign country)
MOTHER
14. Maiden name Mary Perkins
15. Birthplace — (City, town, or county) Miss. 1 (State or foreign country)
16. (a) Informant Hospital Records
(b) Address Koch Hosp. Koch, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 1, 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Macon, Miss.
18. (a) Signature of funeral director English Und. Co
(b) Address 2931 Lucas Ave
19. (a) 1-31-47 (Date received local registrar) (b) Ruth J Allen MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 26 year 47 hour 8 minute 10 A M.
21. I hereby certify that I attended the deceased from 8-2 — 1946 to 1-26 1947; that I last saw h... alive on 1-26 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis — Duration About 7 Mons.
Due to
Due to 13 b
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

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 0
23. Signature John T. Kalish (M. D. or other)
Address Robert Koch Hospital Date signed 1-26-47

(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 Burleson English

Licensed Embalmer No. 4208

P. O. Address 2931 Lucas, Ave.

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.