

3. No. 2
-12-45
5-17-39
I X47070

DEPARTMENT OF HEALTH
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14952**

FILED MAY 9 1947
318

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

Registrar's No. **268**

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:
Enroute City Hospital 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis** 17
(If outside city or town limits, write "RURAL")
(d) Street No. **2814 Market St.** 9
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **James W. Cook**
3. (b) If veteran, name war **No** (c) Social Security No. **491-12-6122**
4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Divorced**
6. (b) Name of husband or wife **Dorothy Cook**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **About 1897**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **19**
year **1947** hour **8:40** minute **A.** 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 _____
Oedema of Brain; Alcoholism;
Duration _____

8. AGE: Years Months Days If less than one day
About 50 hr. _____ min.

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace **Helena Arkansas**
(City, town, or county) (State or foreign country)
10. Usual occupation **Retired**
11. Industry or business **Building Contractor**
MOTHER FATHER { 12. Name **Unknown** 9
13. Birthplace **Unknown** 9
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown** 9
15. Birthplace **Unknown** 9
(City, town, or county) (State or foreign country)

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **Dorothy Hagedorn**
(b) Address **325 N. Boyle Ave.**
17. (a) **Burial** (b) Date thereof **4-26-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **New St. Peter & Paul**
18. (a) Signature of funeral director **Albert H. Hoppe**
(b) Address **4200 Washington Blvd.**
19. (a) **May 11 1947** (b) **J. F. Brebeck**
(Date received local registrar) (Registrar's signature)

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 **Deluch E. Taylor** (M.D. or other) _____
Address **By Courier** Date signed **4/25/47**

(Licensed Embalmer's Statement on Reverse Side)

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

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 Albert G. Hoffa

Licensed Embalmer No. 2971

P. O. Address.....

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.