

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9917**
Registrar's No. **3178**

#94510

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 1705 Ohio Avenue	

3. NAME OF DECEASED (Type or Print) a. (First) THOMAS b. (Middle) O. c. (Last) COOKE			4. DATE OF DEATH (Month) (Day) (Year) April 7, 1949		
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5. SEX M.	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH Aug. 23 - 1901	9. AGE (In years last birthday) 47	IF UNDER 1 YEAR Months 7	IF UNDER 24 HRS. Days 14	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICK LAYER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ANNISTON, MISSOURI		12. CITIZEN OF WHAT COUNTRY?	
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13a. FATHER'S NAME CHARLES F. COOKE		13b. MOTHER'S MAIDEN NAME FRANCES B. MITCHEM		14. NAME OF HUSBAND OR WIFE VERA M.			
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 490-18-1745		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Vera M. Cooke 1705 Ohio Avenue			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tuberculosis, pulmonary ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH 5 mo.	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from 2/9/49, 19 , to 3/7/49, 19 , that I last saw the deceased alive on 3/7/49, 19 , and that death occurred at 11:55am, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John W. Murphy, M.D.		23b. ADDRESS 1515 Lafayette Ave.,		23c. DATE SIGNED 4/7/49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-9-49		24c. NAME OF CEMETERY OR CREMATORY Mount Hope		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
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DATE REC'D BY LOCAL REG. APR 8 1949		REGISTRAR'S SIGNATURE J. B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A. W. McLaughlin 2301 Lafayette			
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 3850

P. O. Address 2301 Lafayette

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.