

FILED MAY 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17175

4596

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

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 OR TOWN St. Louis, Missouri)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 1109 Walton Avenue.	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) Ada b. (Middle) L. c. (Last) Cox		4. DATE OF DEATH (Month) (Day) (Year) May 24, 1949	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec 28, 1874
9. AGE (In years last birthday) 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Clothing	
11. BIRTHPLACE (State or foreign country) Washington, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME James Edward Lawrence		13b. MOTHER'S MAIDEN NAME Jerusha Johnson	
14. NAME OF HUSBAND OR WIFE James Cox			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 491-14-9690	
17. INFORMANT'S SIGNATURE OR NAME Mary Schelich-Bourbon		ADDRESS Missouri	

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) <u>Gastric Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbidity 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.			
19a. DATE OF OPERATION 5/19/49		19b. MAJOR FINDINGS OF OPERATION Gastric Carcinoma		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) Holt MO	
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? 1159 X	
22. I hereby certify that I attended the deceased from 4/5/49, 19, to 5/24/49, 19, that I last saw the deceased alive on 5/23/49, 19, and that death occurred at 9:00A.M., from the causes and on the date stated above.					
23a. SIGNATURE Robert J. Favell		23b. ADDRESS 624 N. Union		23c. DATE SIGNED 5/24/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5/27/49		24c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery	
24d. LOCATION (City, town, or county) (State) Washington, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe		ADDRESS 4700 Washington Blvd	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAY 24 1949 J. B. Lasater					

(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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed Robert M Murray

Licensed Embalmer No. 3749

P. O. Address St. Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.