

FILED AUG 2 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25456

State File No. \_\_\_\_\_  
Registrar's No. 1461

BIRTH NO. _____		REG. DIST. NO. 217		PRIMARY REG. DIST. NO. 9063		Registrar's No. 1461	
1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, write RURAL and give township) <b>Clayton</b>		c. LENGTH OF STAY (in this place) <b>1</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Clayton</b>		96 21	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>480 Edgewood Dr.</b>				d. STREET ADDRESS (If rural, give location) <b>480 Edgewood Dr.</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Effie</b>		b. (Middle) <b>Florence</b>		c. (Last) <b>Coxwell</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>June 17 1949</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Mar. 16 1867</b>	
9. AGE (In years last birthday) <b>82</b>		IF UNDER 1 YEAR Months		IF UNDER 2 HRS. Hours		IF UNDER 15 MIN. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Carroll County Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13a. FATHER'S NAME <b>Albinus Poole</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Smith</b>		14. NAME OF HUSBAND OR WIFE <b>Ernest Coxwell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Rhota Dollman 480 Edgewood Dr.</b>			
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) <b>Cerebral hemorrhage</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>33, 14</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Diabetes mellitus 61</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>  <b>10 yrs</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>W</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>10-5, 1943</b> , to <b>6-17, 1949</b> , that I last saw the deceased alive on <b>6-17, 1949</b> and that death occurred at <b>6 p. m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>John L. Horner M.D.</b>				23b. ADDRESS <b>114 N. Taylor</b>		23c. DATE SIGNED <b>6-18-49</b>	
24a. BURIAL, CREMATION, REBURYAL (Specify)		24b. DATE <b>6-19-49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>City</b>		24d. LOCATION (City, town, or county) (State) <b>DeSoto, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>6-18-49</b>		REGISTRAR'S SIGNATURE <b>Shirley L. King M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert A. Hoppe Inc.</b>		ADDRESS <b>4700 Washington, St. Louis, MO</b>	

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

96  
2  
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MAY 12 1951

JUN 12 1951

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.

NOE Embalm

Signed \_\_\_\_\_

Student .....

Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

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.