

FILED APR 5 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

10308

State File No. 2857

BIRTH NO. #56663 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2857

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS 28 (If rural, give location) no home	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.			

3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) E. c. (Last) COX			4. DATE OF DEATH (Month) (Day) (Year) March 7th, 1950	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Oct. 7, 1884	9. AGE (In years last birthday) 65
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ohio	12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Henderson Cox	13b. MOTHER'S MAIDEN NAME Anna Unknown	14. NAME OF HUSBAND OR WIFE
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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.	17. INFORMANT'S SIGNATURE OR NAME M. Renard, St. Louis City Hospital	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Gangrene, both feet due to frostbite</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Exposure</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Perforated viscera (not found)</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

19a. DATE OF OPERATION 3/3/50	19b. MAJOR FINDINGS OF OPERATION Generalized Peritonitis	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) H-55X
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

22. I hereby certify that I attended the deceased from 2/22/50, 19__, to 3/7/50, 19__, that I last saw the deceased alive on 3/7/50, 19__, and that death occurred at 5:30 AM from the causes and on the date stated above.

23a. SIGNATURE J. C. Peden, M.D.	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 3/7/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) (✓) ()	24b. DATE MAR 27 1950	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State)
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DATE/REC'D BY LOCAL REGISTRAR'S SIGNATURE MAR 27 1950 J. B. Sarater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Service Inc. 404 Manchester Ave. St. Louis 10, Mo.
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WRITE PLAINLY—USING 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
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.