

U.S. No. 900
REV. 10-28

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38373**

FILED DEC 1 1950

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9882**

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		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
c. LENGTH OF STAY (in this place) LIFETIME		d. STREET ADDRESS (If rural, give location) 1404 HEBERT ST. 26	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1404 HEBERT ST.		d. STREET ADDRESS (If rural, give location) 1404 HEBERT ST.	

3. NAME OF DECEASED (Type or Print) LOUISE K. COOL			4. DATE OF DEATH (Month) (Day) (Year) NOV. 20, 1950		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH OCT. 27, 1886	9. AGE (In years last birthday) 64	10. MONTHS 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) ST. LOUIS MO	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					

13a. FATHER'S NAME FRED BRUNE		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE DAVID E. COOL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME DAVID E. COOL	
				ADDRESS 1404 HEBERT ST.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis		DUPLICATE TO (b) Atherosclerosis			1-13-50	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUPLICATE TO (c) _____			1-13-50	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						

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)		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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR 4221	
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22. I hereby certify that I attended the deceased from **Oct 20, 1950** to **Nov 20, 1950** that I last saw the deceased on **Nov 20, 1950** and that death occurred at **4:30 PM**, from the causes and on the date stated above.

23a. SIGNATURE Wendell Bernier, M.D. (Degree or title)		23b. ADDRESS 3802 N Grand Blvd		23c. DATE SIGNED 11-21-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 11-23-50		24c. NAME OF CEMETERY OR CREMATORY FRIEDENS LEM.	
				24d. LOCATION (City, town, or county) (State) ST. LOUIS MO.	

DATE RECD BY LOCAL REG. NOV 21 1950		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE SUEDMEYER & SONS	
				ADDRESS 3934 W. 20 ST.	

(Licensed Embalmer's Statement on Reverse Side)

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

On 10/20/50
Bernier & Stanger

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

Merville B. Frohwitter

Signed.....

Student Embalmer

Licensed Embalmer No. 3696

P. O. Address 3934 N. 28th ST.

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.