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V. 10.48

FILED FEB 14 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2684
0975

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 township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 21 2602 Pine	

3. NAME OF DECEASED (Type or Print)	a. (First) Cyus	b. (Middle)	c. (Last) Cox	4. DATE OF DEATH (Month) (Day) (Year) Jan. 28 1952
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5. SEX Male 2	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower 2	8. DATE OF BIRTH Dec. 24, 1883	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Indian Territory		12. CITIZEN OF WHAT COUNTRY? U S A	

13a. FATHER'S NAME Cyus Cox	13b. MOTHER'S MAIDEN NAME Lonese Riley	14. NAME OF HUSBAND OR WIFE None
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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) Unknown	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Elizabeth Rhodes, 2601 N Whittier St	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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 days Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pulmonary Edema		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Undetermined		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Benign Hypertrophy of Prostate			

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) No	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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 610X
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22. I hereby certify that I attended the deceased from 1-27, 1952, to 1-28, 1952, that I last saw the deceased alive on 1-28, 1952, and that death occurred at 7:15p m., from the causes and on the date stated above.

23. SIGNATURE (Degree or title) <i>Harold W. Warren, M.D.</i>	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 1-30-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) In	24b. DATE JAN 31 1952	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. JAN 31 1952	REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service	ADDRESS Manchester Ave.
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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.....

....., **Student Embalmer No.**

working under my personal supervision.

Student
Student Embalmer

Signed.....

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.