

6314

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registrar's No. **1681**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis, Missouri</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Elvins, Mo</b> <b>0940</b>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <b>Rt. #1</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>WILLIAM</b>	b. (Middle) <b>R.</b>	c. (Last) <b>COX</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>FEB. 20, 1952</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Mar. 31, 1879</b>	9. AGE (In years last birthday) <b>72</b>	IF UNDER 1 YEAR Months Days Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (State or foreign country) <b>Fayetteville, Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Andrew Cox</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown Clark</b>	14. NAME OF HUSBAND OR WIFE <b>Amy S.</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>---</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Amy Cox--Rt. #1, Elvins, Mo.</b>	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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  <b>1 year?</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of the lung &amp; metastases to the adrenal</b>		
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	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)	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"/>	21h. HOW DID INJURY OCCUR? <b>163x</b>

22. I hereby certify that I attended the deceased from **2-2-52**, 19\_\_\_, to **2-20-52**, 19\_\_\_, that I last saw the deceased alive on **2-20-52**, 19\_\_\_, and that death occurred at **7:30P.** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Wm. Ercole M.D.</b>	(Degree or Title)	23b. ADDRESS <b>1515 Lafayette Avenue</b>	23c. DATE SIGNED <b>2-21-52</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>2/25/52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Park Lawn Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Missouri</b>
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DATE REC'D BY LOCAL REG. <b>2-23-52</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Wacker-Helderle</b>	ADDRESS <b>3631 Gravois</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

FILED MAR 5 1952

**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. *2645*

P. O. Address *St. Louis, Mo*

**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.