

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36271

State File No.

NOV 13 1952

BIRTH NO. 71605 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9717

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO.</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis Mo</u>		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Christian Hospital</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis 10</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>Warren</u> c. (Last) <u>Cox</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10 20 1952</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>0</u>	8. DATE OF BIRTH <u>10-20-1952</u>
9. AGE (In years last birthday) <u>1</u> IF UNDER 1 YEAR Months <u>5</u> Days <u>—</u>		10. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Warren Hicks Cox</u>		13b. MOTHER'S MAIDEN NAME <u>Fern Campbell</u>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>Warren Hicks Cox</u>	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Prematurity</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Premature labor</u> DUE TO (c) <u>Cause unknown</u> 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 type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify)	
21a. 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? <u>774X</u>		22. I hereby certify that I attended the deceased from <u>10-20, 1952</u> , to <u>10-20, 1952</u> , that I last saw the deceased alive on <u>6 AM 10-20, 1952</u> , and that death occurred at <u>6:40 Am.</u> , from the causes and on the date stated above.	
23a. SIGNATURE <u>Kenneth V Larson MD</u>		23b. ADDRESS <u>607 N. Grand</u>	
23c. DATE SIGNED <u>10-20-52</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>10-21-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>VALHALLA Cem</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>		24e. DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>J. Charles Smith MD</u>	
24f. FUNERAL DIRECTOR'S SIGNATURE <u>Rowland</u>		24g. ADDRESS <u>4104 Maplecrest</u>	

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

Benjamin

Licensed Embalmer No. *4366*

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.