

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40095**
Registrar's No. **10098**

FILED DEC 2 1952

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 Indiana b. COUNTY Clay City	
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 Clay City	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If rural, give location) 8130	
3. NAME OF DECEASED (Type or Print) a. (First) WALTER b. (Middle) JUNIOR c. (Last) COTTER			4. DATE OF DEATH (Month) (Day) (Year) 11 2 52
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 11-21-1921
9. AGE (In years last birthday) 30		10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	11. BIRTHPLACE (City and State or Foreign Country) Clay City, Indiana
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		12. CITIZEN OF WHAT COUNTRY Indiana	
13a. FATHER'S NAME Walter Cotter		13b. MOTHER'S MAIDEN NAME Rose Weatherwax	
14. NAME OF HUSBAND OR WIFE Rose Lee Cotter		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Rose Lee Cotter	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) BRAIN TUMOR, LEFT FRONTAL LOBE (GLIOMA)		19. INTERVAL BETWEEN ONSET AND DEATH 6 WEEKS	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) BRAIN TUMOR, LEFT FRONTAL LOBE (GLIOMA)			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION 10/25/52		19b. MAJOR FINDINGS OF OPERATION (1) Craniotomy, left frontal lobe. (2) Secondary left frontal craniotomy for evac. of clot.	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 11/2 1952		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 193x		22. I hereby certify that I attended the deceased from 10/23 1952 , to 11/2 1952 that I last saw the deceased alive on 11/2 1952 , and that death occurred at 11:05p.m. , from the causes and on the date stated above.	
23a. SIGNATURE JR Bradley		23b. ADDRESS 600 S. Kingshighway Blvd.	
23c. DATE SIGNED 11/3/52		24. NAME OF CEMETERY OR CREMATORY Clay City, Ind.	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Nov. 3, 1952	
24c. LOCATION (City, town, or county) (State) Clay City, Indiana		25. FUNERAL DIRECTOR'S SIGNATURE W. R. Mortuary	
DATE REC'D BY LOCAL REG. NOV 3 1952		26. FUNERAL DIRECTOR'S SIGNATURE W. R. Mortuary	
26. FUNERAL DIRECTOR'S SIGNATURE W. R. Mortuary		27. FUNERAL DIRECTOR'S SIGNATURE W. R. Mortuary	

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 Levin C. Hoffner

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broadway

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.