

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6068**
Registrar's No. **1146**

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 Missouri. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Missouri.		c. CITY OR TOWN St. Louis,	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 2 weeks.		e. STREET ADDRESS (If rural, give location) #5646 Kingsbury Avenue,	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital.			

3. NAME OF DECEASED (Type or Print) a. (First) ELIZABETH		b. (Middle) HARRIS		c. (Last) COBB.		4. DATE OF DEATH (Month) (Day) (Year) Feb'y 7, 1955.	
5. SEX Female.		6. COLOR OR RACE White.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed.		8. DATE OF BIRTH Sep't 1st, 1867.	
9. AGE (In years last birthday) 87.		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home..		10b. KIND OF BUSINESS OR INDUSTRY Housewife.		11. BIRTHPLACE (City and State or Foreign Country) Pomeroy, Ohio.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Evan Harris.		13b. MOTHER'S MAIDEN NAME Jane Johnson.		14. NAME OF HUSBAND OR WIFE Robert Dodd Cobb.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no.		16. SOCIAL SECURITY NO. none.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Robert H. Cobb, #315 No. 4th St.,	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Arteriosclerotic Heart Disease with Decompensation				48 hours	
ANTECEDENT CAUSES		Generalized Arteriosclerosis				unknown	
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		Acute Cystitis				one week	
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION 1/25/55		19b. MAJOR FINDINGS OF OPERATION Removal of cataract				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		4200	

22. I hereby certify that I attended the deceased from **Jan. 28**, 19**55**, to **Feb. 7**, 19**55**, that I last saw the deceased alive on **Feb. 7**, 19**55**, and that death occurred at **12:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE <i>Emmanuel M.D.</i>		(Degree or title)		23b. ADDRESS 634 N. Grand Blvd.,		23c. DATE SIGNED 2-7-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial..		24b. DATE 2/8/55.		24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery.		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri.	
DATE REC'D BY LOCAL REG. FEB 7 1955		REGISTRAR'S SIGNATURE <i>Carl Smith</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS B. R. Lupton & Sons, #7233 Delmar Blv'd.,			

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.....
Signature of Student Embalmer

Signed *Clarence H. Murray*.....

Licensed Embalmer No. *40 N*.....

P. O. Address *H. Lewis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.