

THE DIVISION OF HEALTH OF MISSOURI
 FILED AUG 29 1955 STANDARD CERTIFICATE OF DEATH

State File No. **28524**
 Registrar's No. **1902**

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 500		Registrar's No. 1902	
1. PLACE OF DEATH a. COUNTY St. Louis				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) Rural Wellston		c. LENGTH OF STAY (In days) 17 days		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2039 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Vincent's Hospital				d. STREET ADDRESS (If rural, give location) 6172 Simpson			
3. NAME OF DECEASED (Type or Print) John		b. (Middle) C.		c. (Last) Cox		4. DATE OF DEATH (Month) (Day) (Year) August 14, 1955	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH June 15, 1877	
9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman		10b. KIND OF BUSINESS OR INDUSTRY Specialty Butcher		11. BIRTHPLACE (State or foreign country) Jim Town, Missouri	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman		10b. KIND OF BUSINESS OR INDUSTRY Specialty Butcher		11. BIRTHPLACE (State or foreign country) Jim Town, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME John Wesley Cox		13b. MOTHER'S MAIDEN NAME Mary Jane West		14. NAME OF HUSBAND OR WIFE Mrs. Marion A. Cox			
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. 186 14 2138		17. INFORMANT'S SIGNATURE OR NAME Mrs. Marion A. Cox, wife.		ADDRESS 6172 Simpson, St. Louis, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage				ANTECEDENT CAUSES			3 weeks
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				DUE TO (b) Cerebral Arteriosclerosis			6 months
DUE TO (c) _____				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			6 months
19a. DATE OF OPERATION _____				19b. MAJOR FINDINGS OF OPERATION Cerebral Arteriosclerosis			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		331X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from 6-28- 19 55 , to 8-14- 19 55 ; that I last saw the deceased alive on 8-14- 19 55 , and that death occurred at 6:00 A.m. , from the causes and on the date stated above.							
23a. SIGNATURE J.R. Bauer M.D.				23b. ADDRESS 7301 St. Charles Rock Rd.		23c. DATE SIGNED 8/14/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug. 16-1955		24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery		24d. LOCATION (City, town, or county) (State) St Louis County, Mo.	
DATE REC'D BY LOCAL REG. 8/15/55		REGISTRAR'S SIGNATURE Hebecl R. Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS HOFFMEISTER COLONIAL MORTUARY 6767 Chippewa St. Louis 9, Missouri			

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 _____

working under my personal supervision.

Student Embalmer No.

Signed Harry J. Schumacher

Signed.....
Student Embalmer

Licensed Embalmer No. 2679

P. O. Address 7574 Broadway

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.