

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6322

FILED MAR 5 1956

State File No.

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 1570			
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) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 50 years		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION 5229 Ashland Avenue				e. STREET ADDRESS (If rural, give location) 5229 Ashland Avenue 206th					
3. NAME OF DECEASED (Type or Print) FRANK			a. (First) _____	b. (Middle) COX	c. (Last) _____	4. DATE OF DEATH (Month) (Day) (Year) Feb. 11, 1956			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Dec. 3, 1883			
9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months 2		IF UNDER 1 YEAR Days 8		IF UNDER 1 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Druggist		11. BIRTHPLACE (City and State or Foreign Country) Mississippi			
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13a. FATHER'S NAME Diamond Cox		13b. MOTHER'S MAIDEN NAME Emma Coleman			
14. NAME OF HUSBAND OR WIFE Mae Cox				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) _____					
16. SOCIAL SECURITY NO. _____				17. INFORMANT'S SIGNATURE OR NAME Mae Cox ADDRESS 5229 Ashland Avenue					
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 720.0				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) _____		21f. HOW DID INJURY OCCUR? _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:55 PM. , from the causes and on the date stated above.					
23a. SIGNATURE James M. Kelly (If nurse or other _____)				23b. ADDRESS 1300 Clark		23c. DATE SIGNED 2-14-56			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2/15/56		24c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.			
DATE REC'D BY LOCAL REG. FEB 14 1956		REGISTRAR'S SIGNATURE Charles Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE Charles J. Gates ADDRESS 4107 Finney					

(Licensed Embalmer's Statement on Reverse Side)

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 *Arthur L. Hilliard*

Licensed Embalmer No. 4221

P. O. Address 4107 Finney

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.