

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 12 1957

10106

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar No. **2570**

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, give TOWNSHIP only) OR TOWN St. Louis			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips Hospital				Length of stay in 1b		STREET ADDRESS (If outside, give location) 5316 Maple		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Minerva Middle Cowins Last Cowins				4. DATE OF DEATH Month 3 Day 13 Year 57				
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-5-1894		9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Month 3 Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work			10b. KIND OF BUSINESS OR INDUSTRY Private		11. BIRTHPLACE (City and state or country) Miss. /		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Billy Crockwell				14. MOTHER'S MAIDEN NAME Kathene Slaughter				
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. Unk.		17. INFORMANT Kathene Barlet Address 5316 Maple Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis							INTERVAL BETWEEN ONSET AND DEATH Undet.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							332x	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus- Infarction of Myocardium due to Arteriosclerotic Coronary Thrombosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE	
21. I attended the deceased from 3-11-57 to 3-13-57 and last saw ^{her} him alive on 3-13-57 Death occurred at 10:00 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>Hugh Waters</i> (Degree or title) M. D.				22b. ADDRESS 2601 N. Whittier		22c. DATE SIGNED 3-14-57		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 3-18-57	23c. NAME OF CEMETERY OR CREMATORY Washington Park		23d. LOCATION (City, town, or county) St. Louis, County Mo.		23e. (State)		
24. FUNERAL DIRECTOR J. McClelland ADDRESS 4535 Washington				25. DATE RECD. BY LOCAL REG. MAR 15 '57		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i>		

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *John K. Cunningham*
Licensed Embalmer No. *44*

P. O. Address *2405 0th*

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.