

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041431

STATE FILE NUMBER

FILED NOV 24 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar 10590

300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Jennings 4148 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 10 New Faith Hosp.		Length of stay in 1b	d. STREET ADDRESS 27 7213 a W. Florissant (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Laura A. Cox			4. DATE OF DEATH Month Day Year 11 3 58		
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5. SEX Female /	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1876	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Jefferson County, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME William R. Evans	13b. MOTHER'S MAIDEN NAME Christina Koch	14. NAME OF HUSBAND OR WIFE Robert E. Cox
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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 Robert E. Cox, 7213 a W. Florissant Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 420.0 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

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 Month, Day, Year 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
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21. I attended the deceased from MARCH 16, 1965, to NOV. 3, 1958 and last saw her alive on NOV 3, 1958
Death occurred at 11:00 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Earl W. Lammie M.D.	(Degree or title) O	22b. ADDRESS 6000 W FLORISSANT.	22c. DATE SIGNED 11/4/58
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 11/6/58	23c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County Mo.
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24. FUNERAL DIRECTOR Drehmann-Harral	ADDRESS 1905 Union	25. DATE RECD. BY LOCAL REG. NOV 5 '58	26. REGISTRAR'S SIGNATURE J. Earl Smith, m.d.
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Dr. Earl W. Lanier
6000 W. Florissant

Hrs. 1 - 4 PM Tues. & Wed.

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 *Warren A. Carver*

Licensed Embalmer No. *2534*

P. O. Address

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.