

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003256

FILED VS. FEB 10 1960

Primary Registration District No. \_\_\_\_\_

Registrar's **2 969**

STATE FILE NUMBER

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		a. STATE <b>Mo.</b>	b. COUNTY
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Missouri Baptist Hosp.</b>		c. CITY OR TOWN <b>St. Louis</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
Length of stay in 1b		d. STREET ADDRESS <b>4138 Maryland Ave.</b>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <b>BELLE</b>	Middle <b>M.</b>	Last <b>COBBE</b>	4. DATE OF DEATH	Month <b>Jan.</b>	Day <b>26</b>	Year <b>1960</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-1-1886</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Switch board Operator</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Mo. Baptist Hosp.</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Daniel Cobbe</b>	13b. MOTHER'S MAIDEN NAME <b>Mary J. Higginson</b>	14. NAME OF HUSBAND OR WIFE -----
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Kirkwood,</b> Address <b>Mo.</b> <b>Charles C. Singer 118 E. Bodley</b>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>Hemiplegia right</b>	<b>12-14-59</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerosis</b>	<b>?</b>
	DUE TO (c) <b>Hypertension</b>	<b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <b>334x</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <b>✓</b>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year <b>1-26-60</b>
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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 <b>St. Louis, Mo.</b>	COUNTY	STATE
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21. I attended the deceased from **12-14-59** to **1-26-60** and last saw her alive on **1-26-60**  
Death occurred at **7:30 P.** on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE <b>James G. Fordson, M.D.</b>	(Degree or title)	22b. ADDRESS <b>3903 Olive St</b>	22c. DATE SIGNED <b>1-27-60</b>
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23. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>
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24. FUNERAL DIRECTOR <b>Kriegshauser</b>	ADDRESS <b>4228 S. Kingshighway</b>	25. DATE RECD. BY LOCAL REG. <b>JAN 27 1960</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

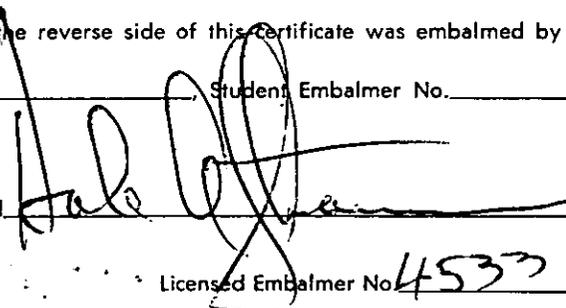
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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed



Licensed Embalmer No. 4537

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.