

**MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-015850**  
STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 1025

**FILED APR 24 1961**

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u>		Length of stay in lb <u>yrs.</u>	c. CITY OR TOWN <u>Kirkwood</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>117 E. Monroe</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>DEWEY</u> Middle <u>JOHN</u> Last <u>COLE</u>			4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1961</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/14/1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Street Department</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City of Kirkwood</u>	9. AGE (last birthday) <u>62</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>Jonesboro, Ark.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Unknown Cole</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Ola Cole, 22 Charles</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Ola Cole, 220 Charles, St. James, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknown Natural Cause</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
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 _____ to _____ and last saw her/him alive on _____. Death occurred at <u>12:30P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Typed name and title) <u>John C. Murphy MD Asst. Health Commissioner</u>		22b. ADDRESS <u>801 S. Brentwood Clayton, Mo.</u>	22c. DATE SIGNED <u>4/17/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4/15/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ellington Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Ellington, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Pfizinger, Kirkwood, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-14-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy MD, Asst.</u>

**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 Ben C. Hoffmann

Licensed Embalmer No. 1436

P. O. Address Howe Co.

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.