

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

9742

-61-038423

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

Registration District No. _____ Primary Registration District _____ Registrar's No. _____

FILED NOV 8 1961 1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b 26 Yrs. c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4245 Shenandoah Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY _____ c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 4245 Shenandoah Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last MATILDA FRANCES COOLEY			4. DATE OF DEATH Month 10 Day 20 Year 61	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/11/84	9. AGE (last birthday) 77 IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Henry Jones		13b. MOTHER'S MAIDEN NAME Winsy Broadfoot		14. NAME OF HUSBAND OR WIFE John (Dec'd.)
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 Pearl Black, 6974 Birkenhead Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, Abdomen Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 199.2				INTERVAL BETWEEN ONSET AND DEATH More than 2 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease originating in PART I (a) Chronic Paralytic Strokes 1st sept 1957 Chronic Bronchitis Arteriosclerosis			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.)		
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 July 12, 1960 to October 20, 1961 and last saw her ^{her} _{him} alive on Oct 18, 1960 Death occurred at 1:22 ^P on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) Leroy E. Ellison M.D.		22b. ADDRESS 3610 So Broadway, St Louis, Mo		22c. DATE SIGNED 10/23/61 (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/23/61	23c. NAME OF CEMETERY OR CREMATORY Round Pond Cemetery	23d. LOCATION (City, town, or county) Salem, Mo.	
24. FUNERAL DIRECTOR McLAUGHLIN'S, 2301 Lafayette ADDRESS		25. DATE RECD. BY LOCAL REG. OCT 23 1961	26. REGISTRAR'S SIGNATURE Road Smith, M.D.	

BY AFFIDAVIT OF

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 *A. G. Fawcett*

Licensed Embalmer No. 3384

P. O. Address *A. G. Fawcett*

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.