

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-032365

7825 STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7825**

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 31 1962

1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in lb 71 years c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri 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) Park Manor Hotel 5560 Pershing Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
--	--	--	--

3. NAME OF DECEASED (Type or print) First Douglas Middle Alexander Last Cox			4. DATE OF DEATH Month August Day 6 Year 1962				
5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-21-1891	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Charles A. Cox			13b. MOTHER'S MAIDEN NAME Sarah A. Rudy			14. NAME OF HUSBAND OR WIFE - - -	

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. - - -	17. INFORMANT Mrs. J.B. Lowell Address Worcester, Mass.
--	--------------------------------------	---

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 insufficiency; Carbon Monoxide poisoning (cardiogenic cause) suffered in fire at P.M. parking garage 25 St Charles on August 6, 1962 about 9:57 P.M. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO accident		INTERVAL BETWEEN ONSET AND DEATH
--	--	----------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 916-6-40		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
---	--	--	--	--

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) See above	
--	--	---	--

20c. TIME OF INJURY 9:57 p.m. 8-6-62	20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) Garage 25	20f. CITY, TOWN, OR LOCATION St. Louis, Mo COUNTY STATE
---	---	---	--

21. I attended the deceased from **10:55 P.** to **10:55 P.** and last saw her/him alive on **8/10/62**
 Death occurred at **10:55 P.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Helen L. Taylor Corcoran	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 8/10/62 (State)
--	--------------------------------	---

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 8/10/62	23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory	23d. LOCATION (City, town, or county) St. Louis County Mo.
--	--------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS Alexander & Sons, 6175 Delmar Blvd.	25. DATE RECD. BY LOCAL REG. AUG 10 1962	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
---	---	---

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT MEDICAL CERTIFICATION

DATE AMENDED	VS 300	Rev. 4/59	1	2	3	4	5	6	7	8	9	10	11	12	13
				21	2	0	3		0	1			ow	75-3	

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 J. Allen Davis Jr.

Licensed Embalmer No. 4093

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.

Aug 7-1952