

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-048246
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12647

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 10 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO.</u>		Length of stay in 1b <u>30 years</u>	c. CITY OR TOWN <u>St. Louis</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. LOUIS CITY HOSP.#.I</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3033 Easton Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>JOHNNIE</u> <u>MAE</u> <u>COLE</u>			4. DATE OF DEATH Month <u>12</u> Day <u>30</u> Year <u>62</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/9/1914</u>
9. AGE (last birthday) <u>48 years</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Little Rock, Ark.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		14. NAME OF HUSBAND OR WIFE <u>Joe Cole (Deceased)</u>	
13a. FATHER'S NAME <u>John Hayward</u>		13b. MOTHER'S MAIDEN NAME <u>Emma (last name not known)</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>Hazel McFadden-4242 W.N. Market St.</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>Shocks, unresponsive;</u> Conditions, if any, which gave rise to above cause (a), starting the underlying cause, last. DUE TO (b) <u>two diarrheas</u> DUE TO (c) <u>Metastatic Ca of the breast</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>6 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>170x</u>			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 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	
21. I attended the deceased from <u>11-12-62</u> to <u>12-30-62</u> and last saw her alive on <u>12-30-62</u> Death occurred at <u>4:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert L. Glass M.D.</u>		22b. ADDRESS <u>1515 LAFAYETTE AVE</u>	22c. DATE SIGNED <u>12-30-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1/3/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Berkeley City, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>RILEY UNDERTAKERS-3759 Finney Ave.</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 2 1963</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

GLASS
USE BLACK INK OR TYPEWRITER RIBBON

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 Gregory Sevan

Licensed Embalmer No. 4580

P. O. Address 2759 Finney

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..