MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

31847

1. PLACE OF DEATH

County..... Registration District No. 791

Township..... Primary Registration District No. 1603

City. St Louis (No. City Hospital St. ..... Ward)

File No.....

Registered No. 9207

2. FULL NAME Louis S. Coons

(a) Residence. No. 1240 N. High St., 25 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 23 1863

7. AGE: Years 63 | Months 10 | Days 20 | If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis
(STATE OR COUNTY)

PARENTS

10. NAME OF FATHER Louis S Coons

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTY) West Virginia

12. MAIDEN NAME OF MOTHER Margaret Kennah

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTY) Ireland

14. INFORMANT Geo F. Coons
(Address) 2618 S. Louisiana St. Louis

15. FILED Oct 17 1927, 19..... Maude Starkoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 16 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 12:20 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Malaria (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? yes DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

10/x 1927 (Signed) C. S. Pitt M. D
(Address) Ovoca

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary — DATE OF BURIAL Oct 18 1927

20. UNDERTAKER Naragin & Sharbaugh — ADDRESS 4413 Washington

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

[illegible] INKLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD