

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

Do not use this space.

4223

**1. PLACE OF DEATH**

County..... Registration District No. 781  
 Township..... Primary Registration District No. 1003  
 City St. Louis (No. 6442 Arsenal St.) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Wesley Coons  
 (a) Residence. No. 6442 Arsenal St. 3 Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred 47 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 21, 1891

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
47 11 25

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

9. BIRTHPLACE (CITY OR TOWN) St. Louis Mo.  
 (STATE OR COUNTRY)

10. NAME OF FATHER James E. Coons

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Missouri  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Kate Dennis

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.  
 (STATE OR COUNTRY)

14. INFORMANT Hilda Coons  
 (Address) 6442 Arsenal St

15. FILED 13 1929 W. C. Starkey REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 17 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec. 17th, 1928, to Jan. 17th, 1929, that I last saw him alive on Jan. 16th, 1929, and that death occurred, on the date stated above, at 10 A m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
apoplexy, from cerebral hemorrhage  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_ IF NOT AT PLACE OF DEATH \_\_\_\_\_

9 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_ WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS (Signed) J. W. Smith M. D.  
 (Address) 6086 Virginia Ave.

\*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 New St. Marcus Cemetery DATE OF BURIAL Jan 21 1929

20. UNDERTAKER Kreighbaum & Co ADDRESS 4278 E. Kingshighway

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

