

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

Do not use this space.

2672

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis Mo** (No. **Northern Hospital**)..... St. Ward)

File No.
 Registered No. **100**
 St. Ward)

2. FULL NAME

Catherine Marie Coan
 (a) Residence, No. **5702 Willow Pl.**, St., **15** Ward. (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 Female
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) Jan 2 1930
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
 1
8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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

10. NAME OF FATHER Martin Coan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis Mo
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Catherine Holdilo

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

14. INFORMANT Martin Coan
 (Address) 5702 Willow Pl.

15. FILED JAN - 3 1930
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-2 1930
17. I HEREBY CERTIFY, That I attended deceased from 1-2 1930, to 7-2 1930 (that I last saw him alive on 1-2 1930, and that death occurred, on the date stated above, at 7 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature birth

159.
 154 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) not fully developed (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 1610
 IF NOT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF -
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? physical
 (Signed) **Edna M Stone**, M. D.
 , 19 (Address) 333 University Club Bldg

*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
DATE OF BURIAL Jan 4/30 19

20. UNDERTAKER Fendler Und Co
ADDRESS 7819 Michigan

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.

