

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

Do not use this space.

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... Primary Registration District No. **1003**  
 City **St. Louis** No. **2315** **Sublette Ave.** St. .... Ward)

File No. ....  
 Registered No. **7191**  
**2065**

**2. FULL NAME**

(a) Residence. No. **2315** **Sublette** St., **13** 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 **Single**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Jan 17, 1923**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**7** **1** **9**

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work **Schoolboy**  
 (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 **Vernus B Coagan**

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

12. MAIDEN NAME OF MOTHER **Ida H. Chesbey**

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

14. INFORMANT **Vernus B Coagan**  
 (Address) **2315 Sublette Ave**

15. FILED **21** 19 **May 11 1930**  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Feb 26, 1930**

17. I HEREBY CERTIFY, That I attended deceased from **Feb 14**, 19... to **Feb 25**, 19... that I last saw him alive on **Feb 25**, 19... and that death occurred, on the date stated above, at **5:40 a.m.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Pneumonia**

CONTRIBUTORY (SECONDARY) **101A**  
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **No** DATE OF

WAS THERE AN AUTOPSY? **No**

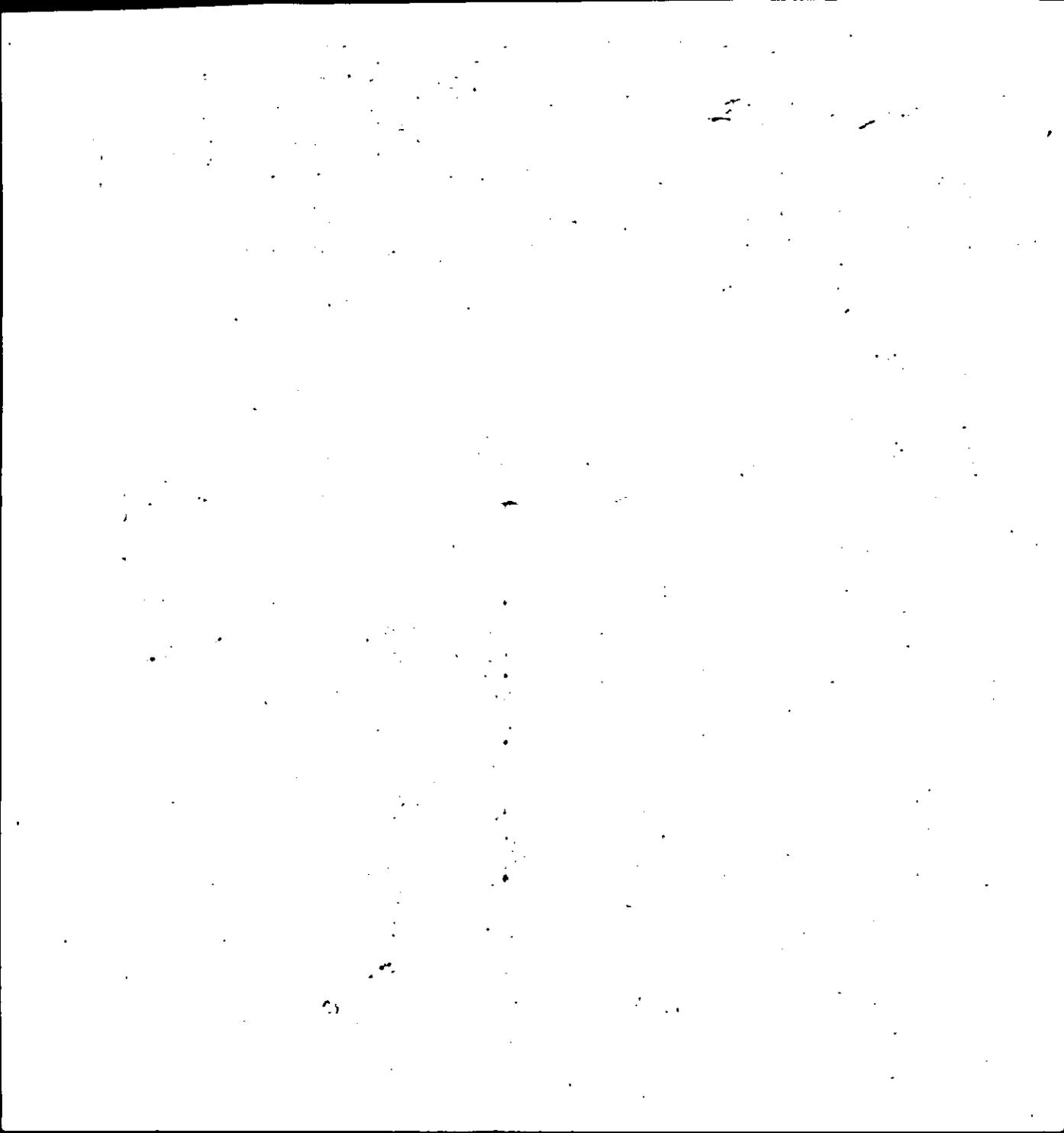
WHAT TEST CONFIRMED DIAGNOSIS **none**  
 (Signed) **D. W. ...**, M. D.

**2-26 1930** (Address) **2418 1/2 Grand**

\*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 **Greenfield Hill** DATE OF BURIAL **Feb 28, 1930**

20. UNDERTAKER **Keegan & Co.** ADDRESS **4228 King**



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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County St. Louis Registration District No. 991 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 1003 Registered No. 2065-  
 City St. Louis (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Dennis F. Coagan  
 (a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S  
(Write the word)

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY)

10. NAME OF FATHER \_\_\_\_\_

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

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

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

14. INFORMANT \_\_\_\_\_  
 (Address) \_\_\_\_\_

15. FILED 1-26-30 Max C. Staley  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 26 19 30

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Pneumonia  
Primary infection given  
Phone by Rev. Dr. P. Wright  
City of U.S. 4 24-30  
 (duration) yrs. mos. ds.

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

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

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.  
 , 19 (Address)

\*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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

1614-S