

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

Do not use this space.

14778

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

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

File No.

Registered No. **4188**

St. Ward)

2. FULL NAME

(a) Residence. No. **1805 Olive** St., **23** Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **17** 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **March 21 1895**

7. AGE YEARS **35** MONTHS DAYS **23** If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work **codebookman** (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) **St. Louis Missouri**

10. NAME OF FATHER **Philip Coates**

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

12. MAIDEN NAME OF MOTHER **Frances Perry**

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

14. INFORMANT **Dr. Norman** (Address) **City Hospital**

15. FILED **APR 25 1930** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 13 1930**

17. I HEREBY CERTIFY, That I attended deceased from **March 29 1930** to **April 13 1930** that I last saw him alive on **April 13, 1930** and that death occurred, on the date stated above, at **1:30 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Pulmonary Tuberculosis, Far Advanced
23A (duration) ? yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **SI** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH **1805 Olive.**

DID AN OPERATION PRECEDE DEATH? **no** DATE OF **✓**

WAS THERE AN AUTOPSY? **no.**

WHAT TEST CONFIRMED DIAGNOSIS **X-ray Chest**
(Signed) **Ray Margulies, M. D.**
4/14, 1930 (Address) **City Hospital**

*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 **St. Louis U.** DATE OF BURIAL **4/22 1930**

20. UNDERTAKER **Walter Richter** ADDRESS **3500 Rutledge St.**

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.

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Coast