

**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.....

Township.....

Primary Registration District No.....

City.....

(No. *4965 McPherson*)

34473

File No.....

Registered No. **9847**

St. Ward)

2. FULL NAME

(a) Residence. No. *4965 McPherson* Ward *12*
(Usual place of abode)

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. (If nonresident give city or town and State)

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) *April 16, 1864*

7. AGE..	YEARS <i>66</i>	MONTHS <i>5</i>	DAYS <i>28</i>	IF LESS than 1 day, hrs. or min.
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8. OCCUPATION OF DECEASED *Retired Clerk of Shapleigh Hdw Co*

(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)..... *St. Louis Mo*
(STATE OR COUNTRY)

10. NAME OF FATHER *Edward Coons*

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

12. MAIDEN NAME OF MOTHER *Mrs. Sella Wells*

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

14. INFORMANT *Marya Coons*
(Address) *4965 McPherson*

15. FILED *5* 19 *May 6* *Starkes*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 14th 1930*

17. I HEREBY CERTIFY, That I attended deceased from *September 12^d 1930* to *October 14th 1930* that I last saw h. *alive* on *October 14th 1930*, and that death occurred, on the date stated above, at *11.45 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial Nephritis.
1 yr. (duration) *1* yrs. mos. ds.

CONTRIBUTORY *Arterio Sclerosis.*
(SECONDARY) (duration) *2* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? *Not at place of death.*
HAD AN OPERATION PRECEDE DEATH? *No.* DATE OF *✓*
*WAS THERE AN AUTOPSY? *No.*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*
(Signed) *Victor Gabriel*, M. D.
Oct 14, 1930 (Address) *3508 Market St. Louis.*

*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 *Bellefontaine* DATE OF BURIAL *Oct 16 1930*

20. UNDERTAKER *Ch. Lupton* ADDRESS *2449 Olive*

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.

Handwritten notes, possibly a name or address, mostly illegible.

Lat = 50.2.

3508 Market
Jeff. 8613
2 ³⁰ or 3 pm

