

REC'D SEP 12 1938

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

26915
Do not use this space.

791
1008

6929

1. PLACE OF DEATH

(a) County Registration District No.
(b) Township St. Louis Primary Registration District No.
(c) City St. Louis (d) Street No. Dr. Paul Hospital Registered No.
(If death occurred in Hospital or Institution, write its name instead of street and number) St.
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S. of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 4960 Northland St. 6
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John C. Coffey
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 14, 1873
7. AGE YEARS 65 MONTHS 4 DAYS 18 If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc. At Home
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 2, 1938
22. I HEREBY CERTIFY, That I attended deceased from March 1st, 1938, to Aug 2, 1938
I last saw h. alive on Aug 2, 1938 Death is said to have occurred on the date stated above at 3 p.m.
The principal cause of death and related causes of importance were as follows:

Congestive Heart Failure
75
Date of onset July 15, 1938
Other contributory causes of importance: Hypertensive Heart Disease

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Missouri

13. NAME Phillip Quinn

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

15. MAIDEN NAME Mary O'Shea

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT (ADDRESS) Edith Coffey 4960 Northland

18. BURIAL, CREMATION OR REMOVAL PLACE Calvary DATE Aug 5 38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Chas. F. Stuart 1225 Union Blvd.

20. FILED AUG 4 1938 J. F. Budder Local Registrar

Name of operation Date of
What test confirmed diagnosis? Aug 4, 38 Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) D. W. Glavin M. D.
(Address) 401 Humboldt Bldg.

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by

Registered Apprentice No., working under my personal supervision.

Signed

Guy W. Wilkerson

Licensed Embalmer No.

3575

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.