

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1488

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town Koch
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 15 days
(Specify whether)
 In this community _____
years, months or days)

8. (a) PRINT FULL NAME Coney, Luther 500

8. (b) If veteran, name war _____
 8. (c) Social Security No. 4888

4. Sex M 5. Color or race negro
 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 13 1913
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>27</u>	<u>3</u>	<u>17</u>	hr. _____ min. _____

9. Birthplace: Dublin Ia
(City, town, or county) (State or foreign country)

10. Usual occupation Porter

11. Industry or business Furniture store

12. Name Joseph Coney

13. Birthplace Dublin Ia
(City, town, or county) (State or foreign country)

14. Maiden name Joseph Wright

15. Birthplace Dublin Ia
(City, town, or county) (State or foreign country)

16. (a) Informant Robert

(b) Address 1319 N 8th

17. (a) Burial (b) Date thereof Aug 9 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Excelsior Woods

18. (a) Signature of funeral director W. L. Beal and Co.

(b) Address 272 N. 2nd Ave

19. (a) AUG 6 - 1940 (b) I. R. Meyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 1319 N 8th
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 1
 year 1940 hour 112 minute 00 noon

21. I hereby certify that I attended the deceased from July 17, 1940 to August 1, 1940

that I last saw him alive on August 1, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to _____

Due to 236

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature Robert F. Schryer (M. D. or other) _____

Address Robert Koch Hosp Date signed 8/2/40

Dr. Durrant

3 in A.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 *Birdie Red Under*

Licensed Embalmer No. *2929*

P. O. Address.....

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

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