

NOV 16 1940

791

Primary Registration District No. **1003**

Registrar's No. **8441**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Alexian Brothers Hosp.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 days  
 (Specify whether  
 In this community 60 years  
 years, months or days)

3. (a) PRINT FULL NAME Walter R. Coryell +

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Carrye C. Coryell 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Apr. 14, 1854  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>86</u>	<u>5</u>	<u>27</u>	hr. _____ min.

9. Birthplace Nichols, N.Y.  
 (City, town, & county) (State or foreign country)

10. Usual occupation Physician

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Emanuel Coryell

13. Birthplace N.Y.  
 (City, town, or county) (State or foreign country)

14. Maiden name Mathilda Thayer

15. Birthplace N.Y.  
 (City, town, or county) (State or foreign country)

16. (a) Informant Carrye C. Coryell  
 (b) Address 3023 Gannon Ave.

17. (a) Burial (b) Date thereof 10-12-40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cem.

18. (a) Signature of funeral director Wagoner Und. Co.

(b) Address 3621 Olive St.

19. (a) OCT 11 1940 (b) J. P. Backus  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis 19  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 4010 Lendell  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 10  
 year 1940 hour 1020 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Subarachnoid hemorrhage  
with epilepsy

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy 82a

Duration

Physician

Underline the cause to which death should be charged statistically.

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)

(b) Means of injury \_\_\_\_\_

23. Signature Alfred Perry (M. D. or other) \_\_\_\_\_

Address Alfred Perry Date signed 10/11/40

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

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.....

*Robert T. Langston*....., Registered Appfentice No. *259*.

working under my personal supervision.

Signed *Neville D. Probert*.....

Licensed Embalmer No. *3696*

P. O. Address *3621 Olive St*

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.