

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

25766

State File No. ....

Registration District No. **791** Primary Registration District No. **1003** Registrar's No. **6712**

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:  
**3611 California Avenue /**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution ..... (Specify whether  
In this community **74 years**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **000**  
(c) City or town **St. Louis** **17**  
(If outside city or town limits, write "RURAL") **224**  
(d) Street No. **3611 California**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country **0**

3. (a) PRINT FULL NAME **Mrs. Christine Coy**  
3. (b) If veteran, name war ..... 3. (c) Social Security No. ....

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **August** day **8th**  
year **1942** hour **7** minute **20 A. M.**

4. Sex **Female** / 5. Color or race **White**  
6. (a) Single, widowed, married, divorced, **Widowed**  
6. (b) Name of husband or wife **Friedrich Coy** 6. (c) Age of husband or wife if  
alive ..... years  
7. Birth date of deceased **November 6, 1858**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Oct 5** 1942 to **Aug 8** 1942  
that I last saw her alive on **Aug 8** 1942  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
**83** **9** **2** hr. min.

Immediate cause of death  
**Chronic arterio Sclerosis** 5yr  
Due to .....

9. Birthplace **Baltimore, Maryland** /  
(City, town, or county) (State or foreign country)  
10. Usual occupation **At Home**

Due to **Cerebral Hemorrhage** 3 days  
Other conditions (Include pregnancy within 3 months of death)  
**g3a**

MOTHER FATHER {  
11. Industry or business .....  
12. Name **Christian Wolf**  
13. Birthplace **Germany** 4  
(City, town, or county) (State or foreign country)  
14. Maiden name **Sophie Adler**  
15. Birthplace **Germany** 4  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations **g3a**  
Of autopsy **g3a**  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. Rudolph Gaehler**  
(b) Address **3611 California**  
17. (a) **Burial** (b) Date thereof **Aug. 11, 1942**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Concordia Cemetery**  
18. (a) Signature of funeral director **Beiderwieden F. H. Inc.**  
(b) Address **1936 St. Louis Avenue**  
19. (a) **AUG 10 1942** (Date received local registrar)  
**J. F. Busch** (Registrar's signature)

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) **0**  
(e) Means of injury **0**  
23. Signature **Adam L. Spangman** (M. D. or other) **MD**  
Address **1439 W. 39th** Date signed **8/8/42**

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

00  
17  
9

Dr. Adam G. Youngm  
5439 Hawaii

8-9  
1-3  
6-8

**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.....  
Licensed Embalmer No.....  
P. O. Address..... 8757 - 1936 W. Louis

**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, fact should be so stated above.**