

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Registration District No. **312** Primary Registration District No. **1002** Registrar's No. **9825**

1. PLACE OF DEATH:  
(a) County **St. Louis**  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**3225 N. Florissant Ave.**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **8-Months**  
In this community **40 yrs.** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo.** (b) County **St. Louis**  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3225 N. Florissant Ave.**  
(If rural, give location)  
(e) Citizen of foreign country? **0** (Yes or No)  
If yes, name country **0**

3. (a) PRINT FULL NAME **William Coughlin**  
(b) If veteran, name war **None**  
(c) Social Security No. **None**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Nov.** day **24th.**, year **1942** hour **3** minute **P.** M.  
21. I hereby certify that I attended the deceased from **Nov 18**, 19**42** to **Nov 24**, 19**42**  
that I last saw him alive on **Nov 24**, 19**42**  
and that death occurred on the date and hour stated above.

4. Sex **M.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **S.O.**  
6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive **Nov. 12th., 1843** years (Month) (Day) (Year)

Immediate cause of death **Cardio Vase Renal disease**  
Due to **Senility**  
Due to **131**  
Other conditions (Include pregnancy within 3 months of death) **121**

8. AGE: Years Months Days If less than one day  
**99** **0** **12** hr. min.

9. Birthplace **Cinn.** (City, town, or county) (State or foreign country)  
10. Usual occupation **Stone Mason**

11. Industry or business .....  
12. Name **James Coughlin**  
13. Birthplace **Ireland 4** (City, town, or county) (State or foreign country)  
14. Maiden name **Mary Cunningham**  
15. Birthplace **Ireland 4** (City, town, or county) (State or foreign country)

16. (a) Informant **Sister Jeans**  
(b) Address **3225 N. Florissant Ave.**  
17. (a) Burial **Burial** (b) Date thereof **11-25-1942** (Month) (Day) (Year)  
(c) Place: burial or cremation **Cavan**

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

18. (a) Signature of funeral director **Arthur J. Smully**  
(b) Address **3840 Lindell Blvd.**  
19. (a) **NOV 25 1942** (b) **J. J. Bradack** (Date received local registrar) (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) (e) Means of injury .....  
23. Signature **Joe Kessler** (M. D. or other) Address **3565 714th** Date signed **11-24-42**

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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed W. H. Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 35277  
Registrar's No. 982d

Registration District No. 318

Primary Registration District No. 1003

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: 3225 N. Florissant  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8 months  
(Specify whether \_\_\_\_\_)  
In this community 10 yrs  
years, months or days

3. (a) PRINT FULL NAME William Coughlin  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

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

7. Birth date of deceased Nov 12  
(Month) (Day) (Year)

8. AGE: Years 94 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) FEB 11 1943 (b) J. F. Brudeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 Day 24  
year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

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

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

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

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) (e) Means of injury \_\_\_\_\_

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

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

35277