

FILED FEB 18 1943 18

Registration District No. _____ Primary Registration District No. **1000**

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:
8624 Oriole Ave
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **None** (Specify whether
years, months or days)

In this community **Unknown**

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. **8624 Oriole Ave**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **William A. Coe**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **None**

4. Sex **Male**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Carrie E Coe nee Davidson**

6. (c) Age of husband or wife if alive **68** years

7. Birth date of deceased **December 18, 1871**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
71	1	19	hr. _____ min. _____

9. Birthplace **Ancona Ills.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer Retired**

11. Industry or business _____

MOTHER FATHER {

12. Name **Albert Coe**

13. Birthplace **Unknown Ohio**
(City, town, or county) (State or foreign country)

14. Maiden name **Marsina Clark**

15. Birthplace **Unknown Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **Carrie E. Coe**

(b) Address **8624 Oriole Ave**

17. (a) **Burial** (b) Date thereof **2/8/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cemetery**

18. (a) Signature of funeral director **Math Hermann & Son**

(b) Address **2161 East Fair Ave**

19. (a) **FEB 8 1943** (b) **J. F. Bredbeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **February** day **6th**
year **1943** hour **1:50 AM** minute _____ M. _____

21. I hereby certify that I attended the deceased from **Jan. 24**
19 43 to **Feb 6**, 19 **43**
that I last saw h **im** alive on **Feb. 5,** 19 **43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage** **12 da**
Duration

Due to _____

Due to _____

Other conditions **8 1/2**
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings:
Of operations _____

Of autopsy _____

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)

(c) Means of injury _____

23. Signature **Dr. P. D. Stahl** (M. D. or other)
Address **462 N. Taylor Ave.** Date signed **2/7/43**

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.....

Francis A. Williamson

Licensed Embalmer No.....

3565

P. O. Address.....

St Louis Mo.

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.