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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUN 14 1943 318

1003

Registrar's No.

5093

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 Bros. Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 2 Weeks  
In this community 50 years (Specify whether years, months or days)

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. 315 So. Broadway  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME John B. Coryell

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 widowed  
6. (b) Name of husband or wife Nellie F. Coryell 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased about Sept 10 1864  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
78 8 20 24 hr. min.

9. Birthplace Nichols New York  
(City, town, or county) (State or foreign country)

10. Usual occupation Physician

11. Industry or business Self

12. Name Emanuel Coryell  
13. Birthplace New York  
(City, town, or county) (State or foreign country)

14. Maiden name Mathilda Thayer

15. Birthplace New York  
(City, town, or county) (State or foreign country)

16. (a) Informant Wm C. S. Forsythe  
(b) Address 7522 Forsythe Blvd.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/3/43  
(Month) (Day) (Year)

(c) Place of burial or cremation Bellefontaine

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

(b) Address 3621 Olive St.

19. (a) JUN 2 1943 (Date received local registration) J. J. Brudick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31 year 1943 hour 1 minute 30 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 Pulmonary Embolism  
Long abscess - right  
Femoral fracture  
Right leg was struck by a  
wrench operated by one  
Herman Christian Pott in  
front of Alexian Bros Hospital  
Other conditions about 11:15 PM April 28 1943  
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:  
Of operations 176  
Of autopsy 21

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) accident  
(b) Date of occurrence Apr 28 1943  
(c) Where did injury occur? at home  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Public Place

While at work? no (Specify type of place) (e) Means of injury Cuts

23. Signature Alfred Perry (M. D. or other) Address Seiput floor Date signed 6/2/43

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

MOTHER FATHER

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**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.....

*Neville B. Frohwitter*

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, fact should be so stated above.**