S. No. 2
M—2-43
FILED JUL 31 1943

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 22873

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6669

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Pacific Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 999

(a) State Arkansas (b) County Bowie 2

(c) City or town Texarkana
(If outside city or town limits, write "RURAL")

(d) Street No. 1513 Ash Street.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 2

3. (a) PRINT FULL NAME William Richard Coley

3. (b) If veteran, name war Spanish American

3. (c) Social Security No. 702-16-7992

4. Sex m

5. Color or race W

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

6. (b) Name of husband or wife Mamie Coley

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

7. Birth date of deceased February (Month) 18 (Day) 1880 (Year)

8. AGE: Years 63 Months 5 Days 4 If less than one day hr. min.

9. Birthplace Howard County (City, town, or county) Arkansas (State or foreign country)

10. Usual occupation Conductor

11. Industry or business Missouri Pacific R. R.

FATHER
12. Name William T. Coley
13. Birthplace Howard County (City, town, or county) Arkansas (State or foreign country)

MOTHER
14. Maiden name Mary Kennedy
15. Birthplace Howard County (City, town, or county) Arkansas (State or foreign country)

16. (a) Informant Mrs. W. R. Coley

(b) Address Texarkana, Texas

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/23/43 (Month) (Day) (Year)

(c) Place: burial or cremation Texarkana, Arkansas

18. (a) Signature of funeral director Albert H. Hoppe, Inc

(b) Address 4700 Washington Blvd.

19. (a) JUL 23 1943 (Date received local registrar) (b) J B Bredeck (Registrar's signature)

JUL 23 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 22 year 1943 hour 8 minute 15 P.M.

21. I hereby certify that I attended the deceased from 7/19/43 19 to 7/22/43 19 ; that I last saw him alive on 7/22/43 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Surgical Shock
Myocardial Weakness
Due to Hypertension

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Hypertrophy Prostate
Of autopsy not done

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature D. J. A. O'Dowd (M. D. or other)

Address Mo. Pacific Hospital Date signed 7/23/43

(Licensed Embalmer's Statement on Reverse Side)

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.....By. W. Wilkinson

Licensed Embalmer No.....3575

P. O. Address.....

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.