

Registration District No. **318**

Primary Registration District No. **1003**

FILED JUL 31 1944

1. PLACE OF DEATH:

(a) County _____
 (b) City or town **St Louis Mo.**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
2330 A Albion Place. /
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **HENRY C. COULSON**

3. (b) If veteran, name war **World War No 1** 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Ica Coulson** 6. (c) Age of husband or wife if alive **45** years

7. Birth date of deceased **Nov 4 1890**
(Month) (Day) (Year)

8. AGE: Years **53** Months **8** Days **13** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Barber**

11. Industry or business _____

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant's own signature **Ica Coulson**

(b) Address **2330 Albion Place.**

17. (a) **Burial** (b) Date thereof **7/20/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **National Cem.**

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

(b) Address **2906 Groves Ave.**

19. (a) **JUL 19 1944** (b) **J. J. Bredon**
(Date received local registrar) (Registrar's signature)

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. **2330 A Albion Place.**
(If rural, give location)
 (e) If foreign born, how long in U. S. A. **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **17**
 year **1944** hour **4:15** minute _____ P. **A.**

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 _____

BILATERAL LOBER PNEUMONIA:

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

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 **Thomas P. ...** (M. D. or other) _____

Address **1000 ...** Date signed **7/19/44**

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

REV. 5-1-39 I 101511

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

000
11
923

108

PHYSICIAN
 Underline the cause to which death should be charged statistically.

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 Albert G Hoppe
Licensed Embalmer No. 2971
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, above space should be left blank.