

FILED OCT 24 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. 6076

Registrar's No. 2084

1. PLACE OF DEATH:

(a) County ST LOUIS  
(b) City or town MANCHESTER  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
MANCHESTER NURSING HOME  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 MO 15 DA  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days) 4

3. (a) PRINT FULL NAME EMMA ROSE COOMBS

3. (b) If veteran, name war No. \_\_\_\_\_  
3. (c) Social Security No. None

4. Sex F 5. Color or race W  
6. (a) Single, widowed, married, divorced W 2

6. (b) Name of husband or wife Harry L. Coombs 11/14/14  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 4 10 1860  
(Month) (Day) (Year)

8. AGE: Years 84 Months 6 Days \_\_\_\_\_  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Kansas City, Mo: - German  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

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

MOTHER FATHER  
12. Name W.M. SEEGER  
13. Birthplace GERMANY it  
(City, town, or county) (State or foreign country)  
14. Maiden name U.N. KNOWN  
15. Birthplace GERMANY  
(City, town, or county) (State or foreign country)

16. (a) Informant Edwin S. Coombs  
(b) Address 61 Aberdeen Place

17. (a) Burial (b) Date thereof 10/11/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery,

18. (a) Signature of funeral director Robert J. Ambruster  
(b) Address Clayton Rd. at Concordia Lane

19. (a) Oct 18 1944 (b) E. J. McShuran M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County ST LOUIS 9th  
(c) City or town ST CRAWFORD  
(If outside city or town limits, write "RURAL")  
(d) Street No. 61 ABERDEEN PLACE  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 9  
year 1944 hour 6 minute 30 P M.

21. I hereby certify that I attended the deceased from Dec 1  
1943 to Oct 9 1944;  
that I last saw her alive on Oct 8 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac insufficiency  
9503  
Due to \_\_\_\_\_  
Due to premelys arteriosclerosis

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?

(Specify type of place)  
(e) Means of injury 0

23. Signature G. J. Mullen (M. D. or other) \_\_\_\_\_  
Address 3507 Potomac Date signed 10-10-44

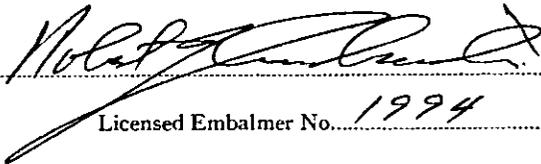
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

96  
00

**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.....



Licensed Embalmer No.....

1994

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.**