

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 20 1945

Registration District No. 318

Primary Registration District No. 1000

Registrar's No. _____

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

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:
1849 Cass ave.
(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

3. (a) PRINT FULL NAME Sister M. Mathew (Coessens)

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased February 14 1877
(Month) (Day) (Year)

8. AGE: Years 67 Months 10 Days 23 If less than one day _____ hr. _____ min.

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

10. Usual occupation Teacher Religious

11. Industry or business _____

12. Name Louis Coessens 4

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

14. Maiden name Rose 4
(City, town, or county) (State or foreign country)

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

16. (a) Informant Sister M. Regina 12

(b) Address 1849 Cass ave

17. (a) Burial (b) Date thereof Jan. 9, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director C. Hoffmeister U. & L. Co.
 (b) Address 7814 S. Broadway St. Louis, Mo.

19. (a) JAN 8 1945 J. F. Bredeck
(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. 1849 Cass ave.
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 7
 year 1945 hour 4 minute 45 A.M.

21. I hereby certify that I attended the deceased from Jan 6, 1945, to Jan 7, 1945
 that I last saw her alive on Jan 6, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis 7 days
Cardiac muscular vessel disease mit. hypertension 2 yrs

Due to _____
 Due to _____

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? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature R. R. Hume (M. D. or other) _____
 Address 1117 N. Grand Date signed 1/8/45

Dr. R. E. Kane
1117 N. Grand ave. Je. 7141

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From at St Paul Army

CHH 10.0107

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 Harry J. Schumacher
Licensed Embalmer No. 2679
P. O. Address 732 Lemay

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.