

No. 2
-12.45
5-17-39
I X47070

FILED MAR 14 1947
Registration District No. _____

Primary Registration District No. **1003**

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:
St. Lukes 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

3. (a) PRINT FULL NAME DWIGHT W. COULTAS, Sr.

3. (b) If veteran, name war No.

3. (c) Social Security No. _____

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Carrie Cameron Coultas

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased July 25 1886
(Month) (Day) (Year)

8. AGE: Years 60 Months 7 Days 10
If less than one day _____ hr. _____ min.

9. Birthplace Norwich Conn.
(City, town, or county) (State or foreign country)

10. Usual occupation Manufacturers Agent

11. Industry or business _____

12. Name Andrew J. Coultas

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

14. Maiden name Rachel West

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

16. (a) Informant Dwight W. Coultas

(b) Address 7816a. Pershing Avenue.

17. (a) Burial (b) Date thereof March 8/47.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OAK GROVE CEMETERY

18. (a) Signature of funeral director C. R. LUPTON & SONS

(b) Address 7233 DELMAR BLVD

19. (a) 3-7-47 (b) J. F. Budeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County Saint Louis: **96**

(c) City or town Clayton: **2**
(If outside city or town limits, write "RURAL") **MR-3**

(d) Street No. 7816 A. Pershing Ave.
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) **1**
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5
year 1947 hour 5 minute 35 P M.

21. I hereby certify that I attended the deceased from March 3 1947 to March 5 1947
that I last saw him alive on March 5 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Retrosperitoneal hemorrhage **3 days**

Due to Ruptured aneurism of abdominal aorta

Due to _____

Other conditions (include pregnancy within 3 months of death) **96.**

Major findings: Of operations _____

Of autopsy Ruptured aneurism of abd. aorta - hemorrhage

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? _____

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

23. Signature Anthony D. Day (M. D. or other) **96**

Address 7230 Washburn Date signed 3/7/47

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

MOTHER FATHER

APR 30 1947

Dr. Anthony Day
3720 Washington Bl'vd.,
NE-0870.

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

Clarence A. Murray

Licensed Embalmer No.

4011

P. O. Address

St. Louis, Mo

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.