

S. No. 2
M-5-43
v. 5-17-39
I X36671

FILED AUG 4 1947
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis

(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. Louis Children's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Renee Marie Coquelin

3. (b) If veteran, name war ---- 3. (c) Social Security No. ----

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 alive ----- years

7. Birth date of deceased July 22nd, 1947
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>0</u>	<u>0</u>	<u>5</u>	hr. <u>-----</u> min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation -----

MOTHER FATHER

11. Industry or business -----

12. Name William Coquelin

13. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Letha McGee

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

16. (a) Informant William Coquelin

(b) Address 915. Bates, St. Louis, Mo.

17. (a) burial (b) Date thereof 7/28/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Lawn Cemetery

18. (a) Signature of funeral director Wacker-Heldule K. & L. Co.

(b) Address 3634 Gravois, St. Louis, Mo.

19. (a) JUL 29 1947 (b) J. F. Brueck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County oas

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 15 915 Bates Street
(If rural, give location)

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

If yes, name country -----

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27
year 47 hour 3 minute 45 A.M.

21. I hereby certify that I attended the deceased from 7-25- 1947 to 7-27- 1947
that I last saw her alive on 7-27- 1947
and that death occurred on the date and hour stated above.

Immediate cause of death allotofosis,
trachea - scaphoid fistula, postop

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)

(c) Means of injury -----

23. Signature J. F. Brueck (M. D. or other)

Address ----- Date signed -----

Duration -----

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.

No Embalming

Signed.....

Frank J. Gland.

Licensed Embalmer No. *2675*

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.