

FILED OCT 23 1948

Registration District No. 318

STANDARD CERTIFICATE OF DEATH

1003

Primary Registration District No.

State File No. 34015

Registrar's No. 8960

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 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 1 WEEK
 years, months or days

3. (a) PRINT FULL NAME VIRGINIA G COLES3. (b) If veteran,
name war _____3. (c) Social Security No.
NO

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced W
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased OCT 27 1893
 (Month) (Day) (Year)

8. AGE: Years 54 Months 11 Days 21 If less than one day
 hr. _____ min. _____

9. Birthplace ST LOUIS MO
(City, town, or county) (State or foreign country)10. Usual occupation NIL

11. Industry or business _____

12. Name SAMUEL L COLES
 13. Birthplace ELMIRA NEW YORK
 (City, town, or county) (State or foreign country)
 14. Maiden name DAISY WOLKREITZ
 15. Birthplace ST LOUIS MISSOURI
 (City, town, or county) (State or foreign country)

16. (a) Informant HARVEY S COLES(b) Address 10217 ST KATHERINE17. (a) BURIAL (b) Date thereof OCT 16 1948
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation FEEFEE CEMETERY18. (a) Signature of funeral director BAUMANN BROTHERS(b) Address 2504 WOODSON OVERLAND19. (a) OCT 16 1948 (b) J. B. Laater
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County ST LOUIS
 (c) City or town ROBERTSON
 (If outside city or town limits, write "RURAL")
 (d) Street No. FEEFEE RD
 (If rural, give location)
 (e) U.S. of foreign country? NO (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 13
year 1948 hour 7 minute 40 P.M.21. I hereby certify that I attended the deceased from 8-29, 1944, to 10-13, 1948;
that I last saw h.w. alive on 10-29, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Carcinoma nose, accessory sinuses with extension to base of skull & internal nose
 Due to _____
 Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings:
Of operations as aboveOf autopsy none

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 D23. Signature [Signature] (M. D. or other) _____
Address 3720 Washington Date signed 10/14/48

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..... *Oscar F. Mueller*

Licensed Embalmer No. *3039*

P. O. Address. *Overland 14 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov
Registrar's No. 8960

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 _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Virginia G. Coler

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

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

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

7. Birth date of deceased. Oct 22 1909
(Month) (Day) (Year)

8. AGE: Years 54 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) Mo

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

13. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. B. Lasater
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year 1940 hour _____ minute _____ M.

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 _____

Duration

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 _____ (M. D. or other) _____

Address _____ Date signed _____

S-34015