

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20904

State File No.

FILED JUL 15 1949

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1005 Registrar's No. 5745

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (If deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>ada</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>	
c. LENGTH OF STAY (in this place) <u>23 Years</u>		d. STREET ADDRESS (If rural, give location) <u>16-3534 Connecticut</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Josephine Heitkamp Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Louise</u>		b. (Middle)		c. (Last) <u>Coopman</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 1, 1949</u>	
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5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Sept. 6, 1875</u>		9. AGE (to years last birthday) Months Days Hours Min. <u>73</u>	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Bloomington, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
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13a. FATHER'S NAME <u>Unknown Schultz</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Fred Coopman</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Fred Coopman, 3534 Connecticut Street</u>		ADDRESS	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Embolism</u>				INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteric Insufficiency</u>					
		DUE TO (c) <u>Insulation</u>					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>920</u>	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Hit by car</u>	
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22. I hereby certify that I attended the deceased from Jan 5, 1946, to July 1, 1949, that I last saw the deceased alive on July 1, 1949, and that death occurred at 6:25 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>G. A. Meadows M.D.</u>		(Degree or title)		23b. ADDRESS <u>1504 Grand</u>		23c. DATE SIGNED <u>July 2, 1949</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7/5/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Ridge Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield, Illinois</u>	
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DATE REC'D BY LOCAL REG. <u>JUL 3 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Jasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave.</u>		ADDRESS	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. S. T. Vandover

10-11 Sun

2~~6~~8 } body

1504 So Grand

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

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.