

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2371  
917

FILED FEB 10 1950

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Minnesota</u> b. COUNTY <u>Hennepin</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Minneapolis</u>		8225	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4373 West Pine</u>				d. STREET ADDRESS (If rural, give location) <u>4624 Oakland</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>William</u>		b. (Middle) <u>Patnel</u>		c. (Last) <u>Coe</u>	
4. DATE OF DEATH		(Month) <u>Jan.</u>		(Day) <u>28,</u>		(Year) <u>1950</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>May 18, 1870</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months _____	IF UNDER 24 HRS. Hours _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Riverside, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Sylvester Coe</u>		13b. MOTHER'S MAIDEN NAME <u>Ann Rowlands</u>		14. NAME OF HUSBAND OR WIFE <u>Annabel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>Sp. American</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Anna Coe Tilson, 5334 Waterman</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocarditis</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis - general</u>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>  <u>10 years</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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>4221</u>			
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? _____			
22. I hereby certify that I attended the deceased from <u>Dec. 27, 1944</u> , to <u>Jan. 28, 1950</u> , that I last saw the deceased alive on <u>Jan. 28, 1950</u> , and that death occurred at <u>9:25 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Wanda Becker</u> <u>M.D.</u>				23b. ADDRESS <u>3720 Washington</u>		23c. DATE SIGNED <u>1-29-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		24b. DATE <u>1-29-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>	
DATE REC'D BY LOCAL REG. <u>JAN 29 1950</u>		REGISTRAR'S SIGNATURE <u>J.P. Luster</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe, 4700 Washington Blvd.</u>			

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

SEP 14 1958

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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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed No Embalm

Signed.....  
Student Embalmer

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.