

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

40081

State File No.

FILED DEC 2 1952

318

1003

Registrar's No. **10418**

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____					
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		2019			
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital				d. STREET ADDRESS (If rural, give location) 601 Loughborough					
3. NAME OF DECEASED (Type or Print) William Edgar Coley			a. (First)		b. (Middle)		c. (Last)		
4. DATE OF DEATH Nov. 9, 1952		(Month)		(Day)		(Year)			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Oct. ?, 1887			
9. AGE (in years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (City and State or Foreign Country) Jackson Co., Ark.			
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME William A. Coley		13b. MOTHER'S MAIDEN NAME Rosa Ammons		14. NAME OF HUSBAND OR WIFE Rosa			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME H. Overbey ADDRESS 3621 French Ave.					
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peritonitis ANTECEDENT CAUSES Ruptured Stomach Gastric Ulcer DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Arteriosclerotic Heart Dis.				INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hrs	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____		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? _____				5401			
22. I hereby certify that I attended the deceased from Nov 7, 1952 to Nov 9, 1952 that I last saw the deceased alive on Nov 9, 1952 and that death occurred at 4:35a m. , from the causes and on the date stated above.									
23a. SIGNATURE McCelia Reichert, MD (Degree or title)				23b. ADDRESS 3209 WASHINGTON AVE		23c. DATE SIGNED 11/11/52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 11-9-52		24c. NAME OF CEMETERY OR CREMATORY Arnold Cemetery		24d. LOCATION (City, town, or county) (State) Swifton, Ark.			
DATE REC'D BY LOCAL REG. NOV 12 1952		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe ADDRESS 4700 Washington Blvd					
DATE REC'D BY LOCAL REG. NOV 12 1952		REGISTRAR'S SIGNATURE MD		25. FUNERAL DIRECTOR'S SIGNATURE _____ ADDRESS _____					

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

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed J. W. Bentley

Licensed Embalmer No. 3653

P. O. Address St Louis

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.