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FILED DEC 10 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40315

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 11480

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2907 Madison

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: 22.09
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
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d. STREET ADDRESS (If rural, give location): 20 2907 Madison

3. NAME OF DECEASED (Type or Print): a. (First) Mary b. (Middle) Evelyn c. (Last) Coonce
4. DATE OF DEATH (Month) (Day) (Year): 12-3-53
5. SEX: Fem.
6. COLOR OR RACE: Neg.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct. 18, 1901
9. AGE (In years last birthday): 52 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator
10b. KIND OF BUSINESS OR INDUSTRY: Sel-Mor Mfg. Co.
11. BIRTHPLACE (State or foreign country): Mississippi
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: Watkins
13b. MOTHER'S MAIDEN NAME:
14. NAME OF HUSBAND OR WIFE: John W. Coonce
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 492-24-5414
17. INFORMANT'S SIGNATURE OR NAME: John W. Coons ADDRESS: 2907 Madison

MEDICAL CERTIFICATION

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — 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) Myocarditis chronic

DUE TO (c) Rheumatic fever

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 ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 415 X

22. *I hereby certify that I attended the deceased from* 8/3, 19 53 *to* Dec 3, 19 53 *that I last saw the deceased alive on* 12/2, 19 53 *and that death occurred at* 10:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Otto C. Hanse (Degree or title) M.D.
23b. ADDRESS: 3012 Lafayette
23c. DATE SIGNED: 12/4/53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-7-53
24c. NAME OF CEMETERY OR CREMATORY: Washington Park
24d. LOCATION (City, town, or county) (State): 5500 Brown Rd. St. Louis

DATE REC'D BY LOCAL REG. DEC 4 1953
REGISTRAR'S SIGNATURE: J. Carl Smith M.D. mgb
25. FUNERAL DIRECTOR'S SIGNATURE: W. H. Bruce ADDRESS: 4469 Washington
(Licensed Embalmer's Statement on Reverse Side)

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

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 Frederick P. Stark

Signed.....
Student Embalmer

Licensed Embalmer No. 4599

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl
the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.