

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40814

State File No.

11215

FILED DEC 4-1953

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 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 2057			
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis		d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Peoples Hospital		e. STREET ADDRESS (If rural, give location) 5 5666 Cabanne			

3. NAME OF DECEASED (Type or Print) a. (First) Thomas b. (Middle) Mc Coy Jr. c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 11 - 24 - 53		
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5. SEX Male 2	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 9, 1895	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) Miss. /	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Thomas Mc Coy	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Elnora Mc Coy
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 4-95-169384	17. INFORMANT'S SIGNATURE OR NAME Elnora Mc Coy	ADDRESS 5666 Cabanne
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertension, Carolic Nephritis		INTERVAL BETWEEN ONSET AND DEATH 1
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	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 NA	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? 442x
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22. I hereby certify that I attended the deceased from 10/10, 1953, to 11/24, 1953, that I last saw the deceased alive on 11/24, 1953, and that death occurred at 3:20 P.M., from the causes and on the date stated above.

23a. SIGNATURE [Signature]	(Degree or title)	23b. ADDRESS [Address]	23c. DATE SIGNED 11/25/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 11/30/53	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis, Co. Mo.
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DATE REC'D BY LOCAL REG. NOV 27 1953	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE G. Wade Granberry	ADDRESS 4202 Finney
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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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
James A. Carter

Licensed Embalmer No. *4680*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.