

FILED APR 2 1956

STANDARD CERTIFICATE OF DEATH

State File No. 10557

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>2728</u>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL, and give OR TOWN <u>St. Louis</u>)		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>4373 West Pine</u>				e. STREET ADDRESS (If rural, give location) <u>5334 Waterman</u> <u>21290</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Annabel</u>		b. (Middle) <u>C.</u>		c. (Last) <u>Coe</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 15, 1956</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>March 11, 1871</u>	
9. AGE (In years last birthday) <u>85</u>		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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Iowa Falls, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Joshua Collins</u>			13b. MOTHER'S MAIDEN NAME <u>Isabella VanCoughoven</u>			14. NAME OF HUSBAND OR WIFE <u>William T. Coe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Ann Tilson</u> ADDRESS <u>5334 Waterman Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>ARTERIO SCLEROSIS, GENERALIZED (460-942)</u>						<u>5 YEARS</u>	
* This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>CEREBRAL ARTERIO SCLEROSIS (94X-942)</u>				<u>2 YEARS</u>	
		DUE TO (c) <u>SENILE ARTERIO SCLEROTIC NEPHRO SCLEROSIS (710-516)</u>				<u>1 YEAR</u>	
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. <u>BRONCHIO PNEUMONIA UNRESOLVED (361-100.9)</u>				<u>2 WKS</u>	
19a. DATE OF OPERATION <u>None</u>		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>446 X</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>24 May, 1955</u> , to <u>15 March, 1956</u> , that I last saw the deceased alive on <u>15 March, 1956</u> , and that death occurred at <u>2:55 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>John W. Seddon M.D.</u>				23b. ADDRESS <u>4500 West Pine Blvd St. Louis 8, Mo</u>		23c. DATE SIGNED <u>16 March 56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		24b. DATE <u>3-16-56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Crematory</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Co., Mo.</u>	
DATE REC'D BY LOCAL REG. <u>MAR 16 1956</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u> ADDRESS <u>4700 Washington Blvd.</u>			

S. P. (Licensed Embalmer's Statement on Reverse Side)

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

SEP 14 1958

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.....

*710 Embalmer of Meigs
Lawrence H. Meigs*

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.