

health, Welfare Public Service
 4000
 300
 1-56
 All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

58-012718
 STATE FILE NUMBER

FILED MAR 31 1958

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 816

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cool Valley</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Cool Valley</u> <u>4008</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>223 Emerling Drive</u>				Length of stay in lb <u>1-7 1/2</u>		d. STREET ADDRESS (If outside, give location) <u>223 Emerling Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>A.</u> Last <u>Coyne</u>				4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1958</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <u>2</u> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 1, 1882</u>	
9. AGE (In years last birthday) <u>75</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>20</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, open if retired) <u>Housewife-at home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (City and state or country) <u>Ireland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Jack Scannell</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Dean</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. W.L. Kahle, 223 Emerling Dr. Cool Valley</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>4200</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>THROMBOPHLEBITIS LEFT LOWER EXTREMITY</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>		HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>3</u> a. m. <u>00</u> p. m. <u>00</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>3/3/58</u> to <u>3/19/58</u> and last saw her/him alive on <u>3/19/58</u> Death occurred at <u>3 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Carl W. Lamine, M.D.</u>				22b. ADDRESS <u>6000 WEST FLUKISSANT</u>		22c. DATE SIGNED <u>3/21/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>March 22, 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>	
24. GENERAL DIRECTOR ADDRESS <u>3840 Lindell Blvd.</u>				25. DATE RECD. BY LOCAL REG. <u>3-21-58</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Donke M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1-4
6000 W. Flower
Friday

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 

Licensed Embalmer No. 49

P. O. Address 3840

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