

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-024124

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1716

FILED JUL 11 1958

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>Lemay</u>		c. CITY OR TOWN <u>Lemay</u> <u>48700</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>416 W. Holden</u>		d. STREET ADDRESS (If outside, give location) <u>416 W Holden</u>	
Length of stay in 1b <u>YRS</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MABEL ANN COBLE</u>			4. DATE OF DEATH Month Day Year <u>June 25, 1958</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 20, 1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>self employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>music teacher</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13a. FATHER'S NAME <u>Given Lasswell</u>	
13b. MOTHER'S MAIDEN NAME <u>Nancy Stewart</u>		14. NAME OF HUSBAND OR WIFE <u>Len Coble (dec'd)</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>Charles Coble 416 W. Holden</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>Cerebral hemorrhage (hypertension)</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>331X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>Chronic</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT <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>June 21 58</u> to <u>June 25 58</u> and last saw her alive on <u>June 24 58</u> Death occurred at <u>6:00 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Wm C. Dumas M.D.</u>		22b. ADDRESS <u>7702 Lemay Av</u>	22c. DATE SIGNED <u>6/25/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>June 27, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Thomas Kutis 2903 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>6-27-58</u>	26. REGISTRAR'S SIGNATURE <u>Herbert R. Dombke M.D.</u> <u>DR</u>

(Licensed Embalmer's Statement on Reverse Side)

Color, contour, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1000
RE 2-06780
6:30 - 8 P.M.

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]
Signature of Student Embalmer

Signed [Signature]

Licensed Embalmer No. 4347
P. O. Address 2905 [unclear]

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.