

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-024130

STATE FILE NUMBER

FILED JUL 14 1958

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1740

S. 300  
v. 1-57

A

Doctor, coroner, 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

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <del>St. Louis</del> <b>Moline</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>37 Halls Ferry Memorial</b>			Length of stay in lbs <b>3 days</b>	d. STREET ADDRESS (If outside, give location) <b>5874 Plymouth</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary Ann</b> Middle Last <b>Coughlin</b>				4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>1958</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 4, 1879</b>		9. AGE (In years last birthday) <b>79</b>	IF UNDER 1 YEAR Month <b>2</b> Days <b>24</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Burkesville, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Mathew Crowe</b>			13b. MOTHER'S MAIDEN NAME <b>Fox</b>		14. NAME OF HUSBAND OR WIFE <b>Thomas E. Coughlin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Lloyd Coughlin 9426 Eastchester</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic heart</b> DUE TO (b) <b>Disease of Myocardium Failure</b> DUE TO (c) <b>4200</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 wks.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition shown in PART I (a) <b>Terminal Bronchopneumonia &amp; Scurvy</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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 Month, Day, Year a.m. p.m.								
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 <b>April 1955</b> to <b>June 1958</b> and last saw her alive on <b>6-28-58</b> Death occurred at <b>12:10 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Joseph R. Mackey MD</b>				22b. ADDRESS <b>745 N. Olive St. St. Louis, Mo.</b>		22c. DATE SIGNED <b>6-30-58</b>		
23a. BURIAL, CREMATION, REINTERMENT <b>Reinterment</b>		23b. DATE <b>7/1/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Chas. S. Stuart 1225 Union</b>				25. DATE RECD. BY LOCAL REG. <b>6-30-58</b>		26. REGISTRAR'S SIGNATURE <b>Herbert R. Danke MD</b>		

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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 *Lawrence O. Gering* .....

Licensed Embalmer No. *4979* .....  
P. O. Address *St. Louis, Mo* .....

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.