

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-030284

STATE FILE NUMBER

FILED SEP 15 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

7717

S. 300  
1-57

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY - - -  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Mo. b. COUNTY <i>St. Louis</i>                            |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <i>St. Louis</i>   |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <i>Webster Groves</i>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <i>St. Luke's Hospital</i>   |                                  | Length of stay in lb<br><i>0</i>  | d. STREET ADDRESS (If outside, give location)<br><i>562 Garden Ave.</i>                              |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><i>Adelaide C Coy</i>   |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><i>Aug. 7 1958</i>   |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>7/5/1876</i>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>at home</i>   | 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.<br><i>82</i> Months Days Hours Min. |
| 11. BIRTHPLACE (City and state or country)<br><i>Missouri</i>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  |
| 13a. FATHER'S NAME<br><i>Joseph Heitkamp</i>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><i>Frances Klockner</i>  | 14. NAME OF HUSBAND OR WIFE<br><i>Charles J. Coy</i>   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><i>no</i>  |                                  | 16. SOCIAL SECURITY NO.<br><i>none</i>  | 17. INFORMANT<br>Address<br><i>Edith L. Mildred Coy Webster Groves Mo.</i>                           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Mesenteric Thrombosis</i>   |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>24 hr.</i>  |
| DUE TO (b) <i>Arteriosclerosis</i>  |                                  |   | <i>15 yrs.</i>   |
| DUE TO (c)  |                                  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><i>Cerebral thrombosis lwk.</i>  |                                  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |
| 20a. ACCIDENT SUICIDE HOMICIDE<br><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.)<br><i>---</i>  |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>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.)<br><i>---</i>  |                                  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE   |  |
| 21. I attended the deceased from <i>1947</i> to <i>Aug. 7, 1958</i> and last saw her alive on <i>Aug. 6, 1958</i><br>Death occurred at <i>139 A</i> m. on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |  |
| 22a. SIGNATURE (Degree or Title)<br><i>George W. Stuer, M.D.</i>  |                                  | 22b. ADDRESS<br><i>600 N. Union Blvd.</i>   | 22c. DATE SIGNED<br><i>8-7-58</i>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  | 23b. DATE<br><i>8/11/58</i>      | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Calvary Cemetery</i>   | 23d. LOCATION (City, town, or county) (State)<br><i>St. Louis Mo.</i>                                |
| 24. FUNERAL DIRECTOR<br><i>Arthur J. Donnell</i>  |                                  | 25. DATE RECD. BY LOCAL REG.<br><i>AUG 8 '58</i>  | 26. REGISTRAR'S SIGNATURE<br><i>Charles Smith MO</i>   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Corrected by affidavit 11/5/58

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.

NOV 5 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 *Francis Williamson*

Licensed Embalmer No. *3565*  
P. O. Address *3840 Lindel*

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.