

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006989

STATE FILE NUMBER
2 1481

FEB 26 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

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1-57

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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
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri. b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Enroute City Hospital DOA			Length of stay in 1b	d. STREET ADDRESS 2200 Farrar, St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rosa Middle Gladys Last Coker				4. DATE OF DEATH Month Feb. Day 10, Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 1, 1906	9. AGE (In years last birthday) 52	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Crockett County, Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME Benjamin F. Archibald		13b. MOTHER'S MAIDEN NAME (Unknown)		14. NAME OF HUSBAND OR WIFE William E. Coker Sr.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 414-30-4132	17. INFORMANT Address Mack Coker, 10509 Duke Dr., St. Louis 21, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) _____ DUE TO (c) _____ E934.D 46	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
20a. ACCIDENT <input checked="" 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.) Suffered in area struck by					
20c. TIME OF INJURY 2:00 a.m.		Hour _____ Month _____ Day _____ Year _____ 2 10 59 Toledo on July 10, 1959 about 2:00 a.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.) Home		20f. CITY, TOWN OR LOCATION AND COUNTY STATE St. Louis Mo			
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 350 A _____ on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE R. H. Smith, M.D. (Degree or title)				22b. ADDRESS 1300 Chavo		22c. DATE SIGNED 2/10/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2-11-59	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Dyersburg, Tenn.		
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe 4700 Washington, Blvd.			25. DATE RECD. BY LOCAL REG. FEB 11 '59		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.		

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 *Melvin L. Kesner*

Licensed Embalmer No. *4052*

P. O. Address *4911 Washington St. Jones, 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.