

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 791
1000

Primary Registration District No. _____

Registrar's No. 6025

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis

(c) Name of hospital or institution: St. John's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 days
(Specify whether _____)

In this community _____
years, months or days 50 years

3. (a) PRINT FULL NAME David Coughlin 245

8. (b) If veteran, name war No

8. (c) Social Security No. none

4. Sex Male 5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mora Coughlin

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased Dec. 12th. 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

65 6 25 hr. _____ min.

9. Birthplace Ills.
(City, town, or county) (State or foreign country)

10. Usual occupation General Foreman

11. Industry or business Public Service-St. R.R.

MOTHER FATHER

12. Name Timothy Coughlin

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Mary Lynch

15. Birthplace Ills.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mora Coughlin

(b) Address 4868 Farlin Ave.

17. (a) Burial (b) Date thereof 7-10-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Galvary Cemetery

18. (a) Signature of funeral director Frank Hudco

(b) Address 3710 N. Grand Blvd.

19. (a) Jul 8 1939 (b) J. F. Fredrick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4868 Farlin Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7th.
year 1939 hour 6.30 minute A. M.

21. I hereby certify that I attended the deceased from July 1:39
July 7, 1939, to _____, 19____;
that I last saw him alive on July 6, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Acute myocardial failure 12 hrs
Coronary occlusion 12 hrs
Coronary embolism 12 hrs

Due to Past operative prostatic 6 days
resection

Other conditions _____
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: _____

Of operations Myasthenia gravis

Of autopsy AKC

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) None

(b) Date of occurrence _____

(c) Where did injury occur? None
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? no (Specify type of place) (e) Means of injury l

23. Signature J. F. Fredrick (M. D. or other) _____
Address 3901 Park one Date signed 7/8/39

Pranger

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..... Me
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

A. A. Smithers

Licensed Embalmer No. 3916

P. O. Address 3710 N. Grand Blvd.

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 this body is not embalmed, above space should be left blank.