

WALL PAPER - USE OVALING 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27858
Registrar's No. 7358

Registration District No. 1003

Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis 25
(If outside city or town limits, write "RURAL")
(d) Street No. 113 So. 3rd St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME William Coombe 510
3. (b) If veteran, name war UNK 3. (c) Social Security No. UNK

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August day 25,
year 1939 hour 11:15 minute _____ A. M.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Mathilda Coombe
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 19 1873
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from August 16, 1939, to August 25, 1939, that I last saw h. im alive on August 25, 1939, and that death occurred on the date and hour stated above.

8. AGE: Years 66 Months 2 Days 6
If less than one day _____ hr. _____ min.

Immediate cause of death Ulcerative Colitis
Due to _____
Due to _____

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

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

10. Usual occupation MAINTAINANCE

Major findings: Of operations _____
Of autopsy _____

11. Industry or business _____

12. Name Unknown Coombe

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

14. Maiden name ''

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

16. (a) Informant's own signature Wm Coombe

(b) Address 113 So. 3rd St.

17. (a) Burial (b) Date thereof 8/26/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cem.

18. (a) Signature of funeral director E. J. Schmir

(b) Address 3125 Lafayette Ave.

19. (a) AUG 26 1939 (b) J. P. Brink
(Date received local registrar) (Registrar's Signature)

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. A. ... (M. D. or other) _____
Address City Hospital #1. Date signed 8/25/39

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Joe B. Vollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette Ave.

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.