

FILED SEP 5 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 29601

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1665

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Kenloch  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. 9 Monroe Aves 9  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 11  
In this community one month (Specify whether years, months or days) 11

3. (a) PRINT FULL NAME Charles Marion Coen  
3. (b) If veteran, name war ? 3. (c) Social Security No. ?

4. Sex MALE 5. Color or race Col 6. (a) Single, widowed, married, divorced ?  
6. (b) Name of husband or wife ? 6. (c) Age of husband or wife if alive ? years  
7. Birth date of deceased March 4 1905  
(Month) (Day) (Year)

8. AGE: Years 55 Months 5 Days 29 If less than one day hr. min.

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

10. Usual occupation UNKNOWN

11. Industry or business UNKNOWN

12. Name UNKNOWN 9

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

14. Maiden name UNKNOWN

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

16. (a) Informant T. B. Cunningham  
(b) Address 573 1/2 MONROE, KENLOCH MO

17. (a) BURIAL (b) Date thereof 9-9-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Boyd Bros Funeral Home  
(b) Address LIX & STATZ, S. KENLOCH MO

19. (a) SEP - 4 1940 (b) 9R 2nd & MD 3 PH  
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Illinois (b) County Monroe  
(c) City or town JACKSONVILLE  
(If outside city or town limits, write "RURAL")  
(d) Street No. 803 South Fayette  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug. day 31 year 1940 hour 12:30 minute P. M.  
21. I hereby certify that I attended the deceased from July 21, 1940 to Aug 31, 1940  
that I last saw him alive on Aug-31, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion  
Due to arteriosclerosis  
Due to Intestinal Nephritis  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 1-1  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration  
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 Jas. A. Rainey (M. D. or other) 1  
Address 12 Kenloch Park Date signed \_\_\_\_\_

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

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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.....

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

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No.

Primary Registration District No.

Registrar's No.

1665

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town North St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(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)

3. (a) PRINT FULL NAME Charles M. Coen

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife. 6. (c) Age of husband, or wife, if alive year

7. Birth date of deceased (Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 9-0040 (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Aug. Day 31 - Year 40  
year hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19

that I last saw him alive on 19 and that death occurred on the date and hour stated above.

Immediate cause of death

Coronary Occlusion

Due to Arterio Sclerosis

Due to Int. Nephritis Chronic

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

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 John A. Parnass (M. D. or other)

Address St. Louis Date signed

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

SUPPLEMENTARY

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