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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9268**

FILED OCT 27 1943

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

1. PLACE OF DEATH:
(a) County ST. LOUIS
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST. JOHNS HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 DAYS
In this community 27 YEARS
(Specify whether years, months or days)

3. (a) PRINT FULL NAME SISTER M. PATRICIA COFFEY
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased DEC. 9, 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 10 11 _____ hr. _____ min.

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

10. Usual occupation RELIGIOUS

11. Industry or business _____

MOTHER FATHER { 12. Name JOHN B. COFFEY
13. Birthplace IRELAND 4
(City, town, or county) (State or foreign country)
14. Maiden name ANNA GEARY
15. Birthplace IRELAND 4
(City, town, or county) (State or foreign country)

16. (a) Informant SISTER M. RAPHAEL KIELY
(b) Address 5446 CABANNE AVE.

17. (a) BURIAL (b) Date thereof 10-22-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY CEMETERY

18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 88th & Lindell Blvd.
Oct 21 1943

19. (a) _____ (b) J. F. Medical
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 000
(a) State MO. (b) County 175
(c) City or town ST. LOUIS 95
(If outside city or town limits, write "RURAL")
(d) Street No. 5446 CABANNE AVE.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT. day 20
year 1943 hour 2 minute 15 P.
21. I hereby certify that I attended the deceased from October 14th, 1943, to October 20, 1943
that I last saw her alive on October 20, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death _____
Streptococcal B. pneumoniae
Due to _____

Duration
6 days

Due to _____
Other conditions (Include pregnancy within 3 months of death) 107

Major findings: Of operations _____
Of autopsy _____
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 Augustus P. Munsch (M. D. or other) _____
Address 306 Humboldt Hwy Date signed Oct 21/43

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 W H Van Matre

Licensed Embalmer No. 28 257

P. O. Address 4340 Lafayette

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, fact should be so stated above.