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M-2-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32987**
Registrar's No. **9601**

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

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County.....
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
CITY HOSPITAL, No 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 WEEKS
(Specify whether years, months or days)

3. (a) PRINT FULL NAME GEORGE M. COIBION (COIBION)
3. (b) If veteran, name war _____ 3. (c) Social Security No. 493-20-7925

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Cecelia COIBION 6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased April 30, 1893
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 6 1 hr. min.

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

10. Usual occupation Machinist
11. Industry or business Measure Graf Co.

MOTHER FATHER

12. Name John Coibion
13. Birthplace France
(City, town, or county) (State or foreign country)
14. Maiden name Mary Kraeger
15. Birthplace Ills.
(City, town, or county) (State or foreign country)

16. (a) Informant Cecelia Boibion
(b) Address 3506 A Nebraska

17. (a) Burial (b) Date thereof Nov 3/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus

18. (a) Signature of funeral director Thodites & Son
(b) Address 2906 Gravois Ave

19. (a) NOV 1 1943 (b) J. D. Bredek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St Louis (If outside city or town limits, write "RURAL")
(d) Street No. 3506 A Nebraska (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 31
year 1943 hour 10 50 AM/PM _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on Oct 29, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Malignant Hypertension
Due to Malignant Nephrosclerosis with Uremia

Due to _____
Other conditions (include pregnancy within 3 months of death) 1941

Major findings: Of operations _____
Of autopsy None

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) None
(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 William D. Durr (M. D. or other)
Address 1500 Lafayette Date signed 11/16/43

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 E Morris

Licensed Embalmer No. 3360

P. O. Address.....

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.