

Registration District No. 318

Primary Registration District No. 1000

Registrar's No. 1289

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: St. Louis City Hospital  
Max C. Starkloff Memorial  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 Days  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days)

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. 2843 Arlington Ave.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Clara Martin Coyner

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 19,  
year 1943 hour 8:40 minute A. M.

21. I hereby certify that I attended the deceased from December  
2, 1943 to December 19, 1943

4. Sex Female / 5. Color or race White 6. (a) Single, widowed, married, divorced, Wid.

6. (b) Name of husband or wife William 6. (c) Age of husband or wife if alive - years

7. Birth date of deceased January 4, 1874  
(Month) (Day) (Year)

that I last saw her alive on December 19, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>11</u>	<u>15</u>	hr. _____ min. _____

Carcinomatosis

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

Due to Primary Carcinoma of gall bladder

Due to \_\_\_\_\_

10. Usual occupation Housewife

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

11. Industry or business \_\_\_\_\_

MOTHER { 12. Name -----Martin

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

14. Maiden name Margaret Miller

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

16. (a) Informant J.W. Taylor

(b) Address 2843 Arlington

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-43  
(Month) (Day) (Year)

(c) Place: burial or cremation Lakewood Park

18. (a) Signature of funeral director Drehmann-Harral

(b) Address DEC 20 1943  
J.J. Bredsch  
(Date received local registrar) (Registrar's signature)

Major findings: Of operations Carcinoma of gall bladder and liver.  
Of autopsy As above

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 Wesley Wad  
Address 1515 Lafayette Avenue. Date signed 12/20/43

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..... *Warren A. Carver* .....

Licensed Embalmer No..... *3534* .....

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.**