

S. No. 2  
M-5-43  
5-17-39  
I X36671

FILED JUN 26 1946  
318

State File No. \_\_\_\_\_  
Registrar's No. 5402

Registration District No. \_\_\_\_\_ 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:  
3225 N. Florissant Ave. (Littles Sisters)  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 9 Years  
(Specify whether)  
 In this community Dont Know  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3225 N. Florissant Ave.  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Henry Coombs  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 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 March 13, 1870  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
76 3 3 hr. \_\_\_\_\_ min.

9. Birthplace Dont Know Illinois  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_  
 12. Name John Coombs  
 13. Birthplace Dont Know  
(City, town, or county) (State or foreign country)  
 14. Maiden name Ellia Coombs  
 15. Birthplace Dont Know  
(City, town, or county) (State or foreign country)

16. (a) Informant Sister Jaenne  
 (b) Address 3225 N. Florissant Ave.  
 17. (a) Burial (b) Date thereof 6-19-46  
(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 3840 Lindell Blvd.  
 19. (a) JUN 18 1946 (b) J. T. Bremer  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16,  
 year 1946 hour 7 minute P. M.  
 21. I hereby certify that I attended the deceased from June 5 1946 to June 16 1946  
 that I last saw him alive on June 15 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis  
 Duration 0!  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: None  
 Of operations None  
 Of autopsy None

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) Manner of injury \_\_\_\_\_  
 23. Signature Bernard F. Kelle (M. D. or other) \_\_\_\_\_  
 Address 2302 Selahburg St. Date signed 6-17-46

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

MOTHER, FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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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

*Stanley Marshall*

Licensed Embalmer No. *2868*

P. O. Address *3840 Rindell*

**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.**