

No. 2
12-45
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X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12273

FILED JAN 7 1947
318

State File No. _____
Registrar's No. 1188

Registration District No. _____ Primary Registration District No. _____

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:
3353a Market Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 30 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3353a Market Street
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Annie Coolridge

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

4. Sex Female 5. Color or race Negro 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 May 12th 1897
(Month) (Day) (Year)

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

| | | | |
|-----------|----------|-----------|----------------------|
| <u>49</u> | <u>7</u> | <u>13</u> | hr. _____ min. _____ |
|-----------|----------|-----------|----------------------|

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

10. Usual occupation Housekeeper

11. Industry or business _____

12. Name Ned Coolridge

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

14. Maiden name Winnie Hardy

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

16. (a) Informant Robert Coolridge

(b) Address 3353a Market Street

17. (a) Burial (b) Date thereof 12/31/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Chas. J. Gates

(b) Address 4107 Finney Avenue

19. (a) DEC 29 1946 (b) J. F. Prudek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 25
year 1946 hour 1 minute 25 p.M.

21. I hereby certify that I attended the deceased from December 9th 1946 to December 23 1946
that I last saw h. er alive on December 23rd 1946
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Chronic Myocarditis 6 mos.

Due to Hypertension undet.

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy none

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? 0

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature M. A. Weller (M. D. or other) M.D.

Address 6524 & Franklin Av. Date signed _____

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

MOTHER FATHER

000
187
9
0

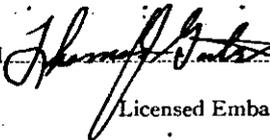
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Thomas J. Gates, Registered Apprentice No.
working under my personal supervision.

Signed



Licensed Embalmer No. 4259

P. O. Address. 4107 Finney Avenue

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.