

No. 2
-12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10668**
Registrar's No. **2930**

FILED MAR 31 1947
Registration District No. **318**

Primary Registration District No. **1003**

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:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 19 days
(Specify whether in this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 2900

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

(d) Street No. 1922 Biddle St
(If rural, give location)

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

3. (a) PRINT FULL NAME Henry Coats

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race Col

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Josephine Coats

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan. 22 1872
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>75</u>	<u>1</u>	<u>23</u>	hr. _____ min. _____

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

10. Usual occupation Laborer

11. Industry or business _____

12. Name Iverson Coats

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

14. Maiden name Masilline ?

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

16. (a) Informant Henry Coats (patient)

(b) Address 1922 Biddle

17. (a) BURIAL (b) Date thereof MAR 24 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director F. A. GREEN

(b) Address 2915 FRANKLIN AVE

19. (a) MAR 19 1947 (b) J. F. Bredeek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 15
year 1947 hour 11 minute 10 A. M.

21. I hereby certify that I attended the deceased from 1-24 1947, to 3-15 1947,
that I last saw him alive on Mar. 15 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease
Duration Undet.

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy No

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 Edw. B. Williams (M. D. or other) 0

Address 2601 N Whittier St Date signed 3/17/47

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 *J. A. Green*
Licensed Embalmer No *2963*
P. O. Address *2915 Franklin*

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.