

FILED NOV 28 1947

10385

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No.

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.....**DePaul Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....**8-days**
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State.....**Mo.** (b) County.....**St. Louis**
(c) City or town.....**Richmond Heights**
(If outside city or town limits, write "RURAL")
(d) Street No.....**1053a Bid Ben Road**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Karen Ann Coughlin**

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

4. Sex.....**F.** 5. Color or race.....**W.** 6. (a) Single, widowed, married, divorced.....**S.**
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased.....**Nov. 2nd., 1947**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 8 hr. min.

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

10. Usual occupation.....**Nil**

11. Industry or business:

12. Name.....**John J. Coughlin**
13. Birthplace.....**St. Louis Mo. U**
(City, town, or county) (State or foreign country)
14. Maiden name.....**Lorraine Green**
15. Birthplace.....**St. Louis Mo. U**
(City, town, or county) (State or foreign country)

16. (a) Informant.....**Mr. John J. Coughlin**

(b) Address.....**1053a Big Ben Road**

17. (a) **Burial** (b) Date thereof.....**11-11-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....**Cemetery**

18. (a) Signature of funeral director.....**Arthur J. Donnelly**

(b) Address.....**3840 Lindell Blvd.**

19. (a) **NOV 10 1947** (b) **J. P. Breda**
(Date received for local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month.....**Nov.** day.....**10th.**
year.....**1947** hour.....**2** P.m. M.

21. I hereby certify that I attended the deceased from.....**Mar. 2**
.....**1947**, to.....**Mar. 10**, 19**47**
that I last saw him alive on.....**Mar. 10**, 19**47**
and that death occurred on the date and hour stated above. Duration

Immediate cause of death.....**Acute Enteritis**
Acute Hypotonia

Due to.....

Due to.....**159**

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

Major findings:
Of operations.....
Of autopsy.....

PHYSICIAN

Underline the cause of 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?.....

(e) Means of injury.....

Signature.....**John A. Hattaway** M. D. or other **M.D.**

Address.....**2807 N. Grand** Date signed.....**11-10**

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

MOTHER FATHER

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.H. Van Matre*

Licensed Embalmer No. *2825*

P. O. Address *4340 Lafayette*

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.