

FILED MAR 30 1951

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

11003

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>3070</u>		Registrar's No. <u>741</u>			
1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WEBSTER GROVES</u>		c. LENGTH OF STAY (In this place) <u>20 YRS.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WEBSTER GROVES</u>		4577			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>310 CLARK</u>				d. STREET ADDRESS (If rural, give location) <u>310 CLARK</u>					
3. NAME OF DECEASED (Type or Print) <u>MRS. IDA COFFIN</u>			a. (First)		b. (Middle)		c. (Last)		
4. DATE OF DEATH <u>MAR 21-1951</u>				5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>				8. DATE OF BIRTH <u>MAY-16-1865</u>		9. AGE (In years last birthday) <u>85</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>SH. BOYGAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>JOSEPH JOHNSON</u>			13b. MOTHER'S MAIDEN NAME <u>ANNA MAXWATT'S WALLACE</u>		14. NAME OF HUSBAND OR WIFE <u>D. COFFIN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>SAM COFFIN</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Hypertensive arteriosclerotic heart disease</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day over 10 yrs.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____		420.0			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR _____					
22. I hereby certify that I attended the deceased from _____, 19 <u>27</u> , to <u>Mar-21, 1951</u> , that I last saw the deceased alive on <u>Mar-21, 1951</u> , and that death occurred at _____ <u>8 P.</u> m., from the causes and on the date stated above.									
23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>19 E. Lockwood, Webster Groves 19, Mo.</u>		23c. DATE SIGNED <u>3-23-51</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>MAR. 23 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>OAK HILL</u>		24d. LOCATION (City, town, or county) (State) <u>KIRKWOOD - MO.</u>			
DATE REC'D BY LOCAL REG. <u>3/23/51</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Webster Groves</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

S. No. 200
v. 10-48

Goodrich

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Lessie Welch* _____

Licensed Embalmer No. *4395* _____

P. O. Address *Palmer Ground W* _____

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.