

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25709

State File No. \_\_\_\_\_

FILED JUL 27 1951

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2698

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> <u>4170</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>North Woods</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>North Woods</u> <u>4170</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4007 Colonial Drive</u>		d. STREET ADDRESS (If rural, give location) <u>4007 Colonial Drive</u> <u>0</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Isabelle</u>	b. (Middle) <u>M.</u>	c. (Last) <u>Coughlan</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>July</u> <u>18</u> <u>1951</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED <u>W. 2</u>	8. DATE OF BIRTH <u>unk. unk. 1869</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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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>St. Louis, Mo.</u> <u>0</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>John Kain</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Kenry</u>	14. NAME OF HUSBAND OR WIFE <u>John J. Coughlan</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Miss Isabel Coughlan, 4007 Colonial Dr.</u>
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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		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>  <u>2 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cancer of the face</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>191X</u>			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>0</u> <u>4201</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 18 July, 1951, to 18 July, 1951, that I last saw the deceased alive on 18 July, 1951, and that death occurred at 1:00 pm., from the causes and on the date stated above.

22a. SIGNATURE <u>Luke A. Knesse MD</u> (Degree or title)	22b. ADDRESS <u>1506 Hodsonmonte ave</u>	22c. DATE SIGNED <u>18 July 51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>July 20, 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>7-19-51</u>	REGISTRAR'S SIGNATURE <u>Robert P. Donke MD</u>	FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>40 Lindell Blvd.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 \_\_\_\_\_

*W.H. VanMatre*

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.