

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33025
7971

FILED SEP 24 1953

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State File No. _____
Registrar's No. _____

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri			c. LENGTH OF STAY (In this place)		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin DesLoge Hospital				e. STREET ADDRESS (If rural, give location) 12 5064 Raymond Avenue., 2129					
3. NAME OF DECEASED (Type or Print) a. (First) Annetta			b. (Middle) Lucille		c. (Last) Coffey		4. DATE OF DEATH (Month) (Day) (Year) August 12 1953		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug 23 1930		9. AGE (In years last birthday) (Specify) 22	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and State or Foreign Country) Missouri			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Raymond Banstetter			13b. MOTHER'S MAIDEN NAME Edna Plaster			14. NAME OF HUSBAND OR WIFE Keith Coffey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Nil		17. INFORMANT'S SIGNATURE OR NAME Keith Coffey		ADDRESS 5064 Raymond Avenue.			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Carcinoma Ovary with generalized metastases						INTERVAL BETWEEN ONSET AND DEATH 3 mo		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) generalized metastases								
	DUE TO (c)								
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								
19a. DATE OF OPERATION 7/20/53		19b. MAJOR FINDINGS OF OPERATION Metastatic choro-ca.						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) 175X					
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 6/27, 1953 , to 8/12, 1953 , that I last saw the deceased alive on 8/12, 1953 , and that death occurred at 4:25 P.M. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Roy V. Boedeker M.D.				23b. ADDRESS 457 N. Taylor			23c. DATE SIGNED 8/14/53		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 8-13-53	24c. NAME OF CEMETERY OR CREMATORY Mansfield Cemetery		24d. LOCATION (City, town, or county) (State) Mansfield, Missouri.				
DATE REC'D BY LOCAL REG. AUG 15 1953		REGISTRAR'S SIGNATURE J. Carl Smith, M.D.			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington				

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.....
Signature of Student Embalmer

Signed.....

John J. Haines

Licensed Embalmer No. *4108*.....

P. O. Address *A. Haines, M.*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.