

Health,
Welfare
Public
Service

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All information on this certificate is to be used for statistical purposes only. It is not to be used for legal purposes. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. If cause of death is due to natural causes, coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18545

FILED JUN 14 1957

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5227**

| | | | | | |
|---|-------------------------------|---|---|---|--|
| 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, give TOWNSHIP only) OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips | | Length of stay in lb | d. STREET ADDRESS 4218 E. Aldine | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First John Middle Coburn Last Coburn | | | 4. DATE OF DEATH Month 5 Day 31 Year 57 | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Unknown | 9. AGE (In years last birthday) 76 | IF UNDER 1 YEAR Months 9 Days 9 Hours 9 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR | | 10b. KIND OF BUSINESS OR INDUSTRY NONE | 11. BIRTHPLACE (City and state or country) UNKNOWN | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME UNKNOWN | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | |
| 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. NONE | 17. INFORMANT Address Will COBURN 4218 E. Aldine | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident | | | | | INTERVAL BETWEEN ONSET AND DEATH undet. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Scleroderma 331x | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 331x | | |
| 20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____ | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | | COUNTY STATE |
| 21. I attended the deceased from 5-26-57 to 5-31-57 and last saw ^{her} him alive on 5-31-57 Death occurred at 7:20 A m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE James Maffey (Degree or title) _____, M.D. | | | 22b. ADDRESS 2601 Whittier Street | | 22c. DATE SIGNED 6-3-57 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) |
| Removal | | 6. 4. 57 | WASHINGTON PARK | | ST. LOUIS COUNTY MO |
| 24. FUNERAL DIRECTOR Price Benevolent Order of Friends | | | 25. DATE RECD. BY LOCAL REG. JUN 4 57 | 26. REGISTRAR'S SIGNATURE J. Carl Smith, MD 11. 8. 13 | |

(Licensed Embalmer's Statement on Reverse Side)

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 *Leroy U. Bonmeister*
Licensed Embalmer No. *45*

P. O. Address *4251 Mac*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitute's 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.