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 -56  
 diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED AUG 19 1957

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

29337  
 STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6748**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. LOUIS</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis 4000</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Baptist</b>		Length of stay in 1b <b>6 wks</b>		d. STREET (If outside, give location) ADDRESS <b>6016 BROWN Road</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>CAROLINE</b> Middle <b>Coughlin</b> Last <b>Coughlin</b>				4. DATE OF DEATH Month <b>7</b> Day <b>17</b> Year <b>1957</b>				
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-27-1898</b>	9. AGE (In years last birthday) <b>58</b>	IF UNDER 1 YEAR Month <b>8</b> Days <b>20</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>De Soto Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>CHARLES GRABER</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>492-20-9958</b>		17. INFORMANT Address <b>Rose BRISCOE 6016 BROWN Rd.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Thrombophlebitis, acute</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)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
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.)					
20c. TIME OF INJURY Hour _____ Month, Day, Year a. m. _____ p. m. _____								
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 <b>July 1</b> to <b>July 17, 1957</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>July 17, 1957</b> Death occurred at <b>3:32 pm</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>James A. Hutchinson, Jr. M.D.</b>				22b. ADDRESS <b>114 No. Taylor St. Louis Mo.</b>		22c. DATE SIGNED <b>7/19/57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>7-20-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis</b>		(State) <b>MO.</b>		
24. FUNERAL DIRECTOR <b>Walter Perimuehle</b>			ADDRESS <b>3819 So. Grand</b>		25. DATE RECD. BY LOCAL REG. <b>JUL 19 57</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>	

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Geo. Dingbernuebe*.....

Licensed Embalmer No. *4*.....

P. O. Address *A. Home*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.