

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-008474

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

1340

FILED FEB 19 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>D.O.A.</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis City Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4935 Thekla</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN THOMAS COUGHLIN</u>			4. DATE OF DEATH Month Day Year <u>February 5, 1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/18/1881</u>
9. AGE (last birthday) <u>78</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meat Industry</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Thomas Coughlin</u>	
13b. MOTHER'S MAIDEN NAME <u>Elizabeth Ford</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) <u>No</u>		16. SOCIAL SECURITY NO. <u>6</u>	17. INFORMANT Address <u>Mrs. Ben Weidle, 1201 Fargo Avenue</u>
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Myocardial Infarction</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>420.0</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 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 <u>3/11/60</u> to <u>2/5/63</u> and last saw him alive on <u>1/14/63</u> Death occurred at <u>7:00 A.m</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert Polashnick M.D.</u> (Degree or title)		22b. ADDRESS <u>3720 Washington</u>	22c. DATE SIGNED <u>2/7/63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/8/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis Missouri</u>
24. FUNERAL DIRECTOR <u>BUCHHOLZ MORTUARY, INC. 5967 W. Florissant</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>FEB 7 1963</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>

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 Ralph C. Lindner

Licensed Embalmer No. 4275

P. O. Address St Louis Mo.

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.