

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-017495

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4495 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DATE AMENDED

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ITEM NO. SHOULD READ

BY AFFIDAVIT OF DOCUMENT

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**FILED MAY 2 1963**

1. PLACE OF DEATH  
 a. COUNTY MISSOURI  
 b. CITY (if outside corporate limits, give TOWNSHIP only) ST LOUIS Length of stay in 1b ST LOUIS  
 c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. HOMER PHILLIPS Inside Limits Yes  No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
 a. STATE MISSOURI b. COUNTY ST LOUIS Inside Limits Yes  No   
 d. STREET ADDRESS (If outside, give location) 4605a ST FERDINAND Reside on Farm Yes  No

3. NAME OF DECEASED First Middle Last  
NELLIE G. COIN  
 (Type or print)

4. DATE OF DEATH Month Day Year  
4-21-63

5. SEX FEMALE 6. COLOR OR RACE COLORED 7. Married  Never Married  Widowed  Divorced   
 8. DATE OF BIRTH 1-5-1892 9. AGE (last birthday) 71 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) RETIRED 10b. KIND OF BUSINESS OR INDUSTRY HOUSE WORK 11. BIRTHPLACE (City and state or country) MINNETH, MO. 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME JEFF. SWINK 13b. MOTHER'S MAIDEN NAME JOSEPHINE MATTHEWS 14. NAME OF HUSBAND OR WIFE MRS SAM McCOY HERCULANEUM, MO.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) \*\*\* 16. SOCIAL SECURITY NO. [REDACTED] 17. INFORMANT Address MRS SAM McCOY HERCULANEUM, MO.

18. CAUSE OF DEATH (Enter only one cause per line)  
 PART I. DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) Status Asthmaticus  
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause, last. DUE TO (b) Arterio Sclerotic Heart Disease  
 DUE TO (c) Arterio Sclerosis  
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200  
 PART III. If deceased was female there a pregnancy in last 90 days.  Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES  NO  20a. ACCIDENT  SUICIDE  HOMICIDE  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  NOT WHILE AT WORK  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 \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
 Death occurred at 9:30 P. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Nelven L. Taylor, Coroner 22b. ADDRESS 1300 Clark Ave 22c. DATE SIGNED 4-24-63

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE 4-28-63 23c. NAME OF CEMETERY OR CREMATORY HERCULANEUM CEM. 23d. LOCATION (City, town, or county) (State) HERCULANEUM, MO.

24. FUNERAL DIRECTOR ADDRESS GENTRY R. POLITTE CRYSTAL CITY, MO. 25. DATE RECD. BY LOCAL REG. APR 24 1963 26. REGISTRAR'S SIGNATURE Earl Smith, M.P.

**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

*Gentry B. Politt*

Licensed Embalmer No.

*3481*

P. O. Address

*Crystal City, 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.