

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-034330
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 543 Registrar's No. 2328

FILED AUG 19 1963

| | |
|---------------------|--------------|
| VS 300 Rev. 4/59 | DATE AMENDED |
| 1 4008 | |
| 2 4008 | |
| 3 | |
| 4 1 | |
| 5 2 | |
| 6 | |
| 7 0 | |
| 8 2 | |
| 9 4201 | |
| 10 | |
| 11 | |
| 12 90-0 | |
| 13 | |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jennings</u> | | Length of stay in 1b <u>66 yrs</u> | c. CITY OR TOWN <u>Jennings</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>9225 Sundown Drive</u> | | d. STREET ADDRESS <u>9225 Sundown Drive</u> | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>LUCIA B. COYNER</u> | | | 4. DATE OF DEATH Month Day Year <u>July 20 1963</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/5/1896</u> |
| 9. AGE (last birthday) <u>66 yrs</u> | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Fred W. Meimholtz</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Emma Paust</u> | | 14. NAME OF HUSBAND OR WIFE <u>Rev. Martin H. Coyner</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>D-B</u> | 17. INFORMANT Address <u>Miss Leona Meimholtz 9225 Sundown Dr.</u> |
| 18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO (b) <u>Rheumatic Valvular Heart Disease</u> DUE TO (c) <u>5 years +</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> |
| 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 checked="" 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. | 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>Sept 23, 1959</u> to <u>July 20, 1963</u> and last saw her alive on <u>May 1, 1963</u> Death occurred at <u>1:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>D. J. Joffe M.D.</u> | | 22b. ADDRESS <u>4222 N. Grand</u> | 22c. DATE SIGNED <u>7-22-63</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>July 23, 1963</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>New Bethlehem Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u> |
| 24. FUNERAL DIRECTOR <u>BEIDERWLEDEN FUNERAL HOME INC.,</u> ADDRESS <u>1936 St. Louis Ave</u> | | 25. DATE RECD. BY LOCAL REG. <u>7-22-63</u> | 26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u> |

D. O. E. TROFAT
4222 No. GRAND
CE-1-2825

11 To 4 PM Monday

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 Harner W. Jritz

Licensed Embalmer No. 3882

P. O. Address St. Louis

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.