No. 2
-1/47
5-17-39

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39536

FILED DEC 6 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10933

1. PLACE OF DEATH:

(a) County

(b) City or town ST. LOUIS MISSOURI
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Barnes Hospital, O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution, ~~three days~~ EIGHT DAYS (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Indiana (b) County Vanderburg 999

(c) City or town Evansville 12
(If outside city or town limits, write "RURAL")

(d) Street No. 722 Line Street., 0
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME GEORGE EDWARD COOGAN

3. (b) If veteran, name war No

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Leota Coogan

6. (c) Age of husband or wife if alive years

7. Birth date of deceased February (Month) 8 (Day) 1890 (Year)

8. AGE: Years	Months	Days	If less than one day
57	9	20	hr. min.

9. Birthplace Evansville (City, town, or county) Indiana (State or foreign country)

10. Usual occupation Merchant

11. Industry or business

MOTHER FATHER

12. Name Thomas Coogan

13. Birthplace Liverpool (City, town, or county) England (State or foreign country)

14. Maiden name Catola Burns

15. Birthplace Louisville (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant Clarence Coogan

(b) Address Evansville, Indiana

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/29/47 (Month) (Day) (Year)

(c) Place: burial or cremation Evansville, Indiana

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.,

19. (a) NOV 30 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 28
year 1947 hour 6. minute 10 P.M.

21. I hereby certify that I attended the deceased from NOV 25, 19 47 to NOV 28, 19 47 that I last saw him alive on 11/28, 19 47 and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Carcinoma of the lung, right, c cerebral and bony metastases

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations none

Of autopsy permission not granted

PHYSICIAN

Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Henry Schwarz (M. D. or other) M.D.

Address Barnes Hospital, Date signed 11-28-47

Jefferson City Printing Co.

(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.....

..... Registered Apprentice No.....,

working under my personal supervision.

Signed Henry H. Brammer

Licensed Embalmer No. 4200

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 this body is not embalmed, fact should be so stated above.