

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

33501
78

1. PLACE OF DEATH

County: Knott Co. Mo. Registration District No. 1086 File No. 78
Township: Colony Primary Registration District No. 6597 Registered No. 18
City: _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Herbert Sherman Coleman

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Mrs. Lula Coleman (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 5 - 1867

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>56</u>	<u>2</u>	<u>12</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Fanner
(b) General nature of industry, business, or establishment in which employed (or employer) Fanning
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Colony Knott Co Mo

10. NAME OF FATHER

Clarkson Coleman

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Ohio

12. MAIDEN NAME OF MOTHER

Samuelia Coleman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Connecticut

14. INFORMANT

Mrs. Lula Coleman
(Address)

15. FILED

11/19, 1923 Le. E. Hoffmann
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 17 1923

17. I HEREBY CERTIFY, That I attended deceased from May 1st May 1923, to Nov 17 1923, that I last saw him alive on Nov. 15, 1923, and that death occurred, on the date stated above, at 7:15 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis
23 ft
92 ft
11 ft (duration) 1 yrs. 6 mos. 15 ds.
CONTRIBUTORY grippe (SECONDARY) (duration) _____ yrs. _____ mos. 12 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? at place of death

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Physician

(Signed) A. H. Lillard, M. D.

, 19 (Address) Libelle Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Colony Knott Co Mo

DATE OF BURIAL

11/19 1923

20. UNDERTAKER

James T. Coder

ADDRESS

Libelle Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OF HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

S. Mr. Bourn has just made out the corrected
out of my Brother's death in his book; and asked
to enclose his note to you. He said it was not
rect to register him as a farmer, so on his
k he filled out # 8. Occupation of Deceased as
"chivist" instead of Farmer. Please return the
ginal certificate to me by registered mail for which
close postage; also tell me whether I shall have
occupation changed to "Machinist" on Mr. Hoffman's
ke origon will look after that.

Mrs. J. T. Bruner.

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CAMBRIDGE

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

1. PLACE OF DEATH

County Knoff Registration District No. 1056 File No. _____
 Township Colony Primary Registration District No. 597 Registered No. _____
 City Colony (No. _____) St. _____ Ward _____

2. FULL NAME

Herbert Seymour Coleman

(a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (or) WIFE Lula A Coleman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept-5-1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
56 2 12

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) Farming
 (c) Name of employer _____

BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Colony Mo

10. NAME OF FATHER Charles A Coleman

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) West Andover Ohio

12. MAIDEN NAME OF MOTHER Paulina Coleman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Southington Connecticut

14. INFORMANT Mrs. Lula A Coleman
 (Address) Rutledge Mo.

15. FILED 11/19 1923 C E Hoffmann
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 17 1923

17. I HEREBY CERTIFY, That I attended deceased from 14 17 November, 1923, to 17 th Nov, 1923
 that I last saw him/her alive on Nov 17, 1922 and that death occurred, on the date stated above, at 7 9 a m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Acute Stenosis

CONTRIBUTORY (SECONDARY) Influenza
 (duration) 2 yrs. — mos. — ds.

(duration) — yrs. — mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH. _____ DATE OF _____

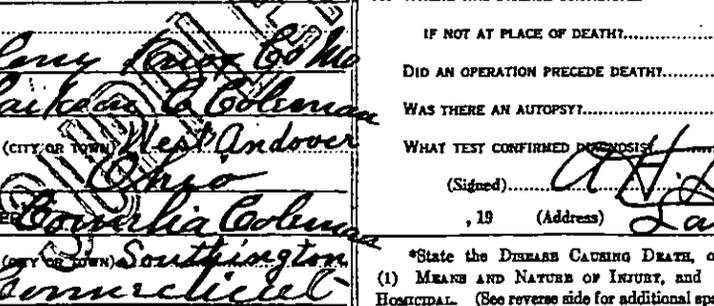
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) A H Deiss M. D.
 , 19 (Address) La Belle Mo.

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL Colony, Mo. DATE OF BURIAL Nov. 19 1923

20. UNDERTAKER James J Coder ADDRESS La Belle, Mo.



1 Mrs. Coleman

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

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