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

Do not use this space.

File No. 42881
Registered No. 12150

1. PLACE OF DEATH

County ..... Registration District No. 784 1003
Township ..... Primary Registration District No. .....
City St. Louis (No. 3433 Pine St. St. ..... Ward)

2. FULL NAME Josie Coleman

(a) Residence. (Usual place of abode) No. 3433 Pine St., 28 Ward. (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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	Col	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 1873

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
abt	55	Unknown		

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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Tenn.

PARENTS

10. NAME OF FATHER Lanke Hill
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Melissie Thomas
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Tenn.

14. INFORMANT Robert Coleman
(Address) 3433 Pine St.

15. FILED ..... 19 ..... Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/11 1928

17. I HEREBY CERTIFY, That I attended deceased from Dec 9, 19 28, to Dec. 11, 19 28 that I last saw him alive on Dec 11, 19 ....., and that death occurred, on the date stated above, at 6:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Endocarditis

9 hr (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) SBS

(duration) ..... yrs. ..... mos. ..... 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) Jos. A. Blaney, M. D.
19 ..... (Address) 1625 Walsh

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL McKenzie Tenn. — DATE OF BURIAL 12/15 1928

20. UNDERTAKER R. M. C. Green — ADDRESS 3517 Laclede Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD