

Registration District No. 274 Primary Registration District No. 4465 Registrar's No. 921

FILED FEB 7 1940

1. PLACE OF DEATH:  
(a) County St. Francois  
(b) City or town Flat River  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County St. Francois  
(c) City or town Flat River  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Mrs. Martha Jane Coleman  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_  
4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Mr. James Otis Coleman 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased January 26 - 1883  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan day 23  
year 1940 hour 1 minute 1 M.  
21. I hereby certify that I attended the deceased from Sept 1, 1939, to Jan 23, 1940,  
that I last saw her alive on Jan 7, 1940,  
and that death occurred on the date and hour stated above.

8. AGE: Years 56 Months 11 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Reynolds County, Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife

Immediate cause of death Apoplexy Cerebral Duration \_\_\_\_\_  
Due to Hypertension  
Due to gcn  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_  
12. Name Mr. Adam Sherrill  
13. Birthplace Reynolds County, Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Jane Edwards Sherrill  
15. Birthplace Reynolds County, Mo  
(City, town, or county) (State or foreign country)  
16. (a) Informant's own signature Mrs. Goldie Park (Daughter)  
(b) Address Cantwell, Mo  
17. (a) Burial (b) Date thereof Jan. 25 - 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Woodlawn, Springfield, Mo  
18. (a) Signature of funeral director Alvin W. Boyd  
(b) Address Flat River, Mo  
19. (a) 1-23-40 (b) C. H. Haggberg  
(Date received local registrar) (Registrar's signature)

Major findings: Of operations \_\_\_\_\_  
Of autopsy none  
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? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature C. H. Haggberg (M. D. or other) MD  
Address Flat River Date signed MO

PHYSICIAN  
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING INK—MADE IN U.S.A.—1 X 1931  
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.

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**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

*Alvin W. Hood*

Licensed Embalmer No. *2780*

P. O. Address *Flat River, 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 this body is not embalmed, above space should be left blank.**