

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

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11457
Registrar's No. _____

Registration District No. 437

Primary Registration District No. 5294

1. PLACE OF DEATH:

(a) County Johnson
(b) City or town Latour Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Residence
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether
In this community All Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Johnson
(c) City or town Latour
(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

Samuel C. Coleman 455

(b) If veteran, name war None

(c) Social Security No. None

4. Sex M. 5. Color or race W.

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

6. (b) Name of husband or wife Amanda H. Coleman

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

7. Birth date of deceased Sept. 6 1863
(Month) (Day) (Year)

8. AGE: Years 76 Months 5 Days 27
If less than one day hr. _____ min. _____

9. Birthplace Johnson Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business Farming

MOTHER FATHER { 12. Name Thomas E. Coleman

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

14. Maiden name Phoebe E. Thistle

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

16. (a) Informant's own signature Markay Coleman

(b) Address Latour, Mo.

17. (a) Burial (b) Date thereof 3/6/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kingsville

18. (a) Signature of funeral director J. H. Munray

(b) Address Latour, Mo.

19. (a) Mar 6 (b) Anna Coleman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4
year 1940 hour 8 minute 45 A.M.

21. I hereby certify that I attended the deceased from Jan 3
1939 to Mar 4 1940
that I last saw him alive on Mar 4 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Chr myocarditis 2 yrs
Duration

Due to chr hypertensive 4 yrs
nephritis

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations no

Of autopsy no

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

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

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(c) Where did injury occur? no
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? no (Specify type of place) (e) Means of injury no

23. Signature Edw. J. Smith (M. D. printed)
Address Garden City, Mo. Date signed Mar 10 1940

RECEIVED
SARATOGA COUNTY HEALTH OFFICE No. 8
Tombstone File Number
Date Filed 11-9-74

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 Me
....., Registered Apprentice No.
working under my personal supervision.

Signed J. H. Murray
Licensed Embalmer No. 2893
P. O. Address Holden, 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.