

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27314

State File No. _____

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **7210**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **ISOLATION HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7/5/40 to 8/21/40**
(Specify whether _____)
In this community _____
years, months or days _____

3. (a) PRINT FULL NAME **Myrtle Coleman. HITE**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **Colored** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Robertson Harvey HITE** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Sept 25th 1898**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	41	10	29	hr. _____ min.

9. Birthplace **Caryle Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Hosewife**

11. Industry or business _____

MOTHER, FATHER { 12. Name **William Coleman. Wade Duncan**
13. Birthplace **Caryle Illinois**
14. Maiden name **Florence Bush. BUSH**
15. Birthplace **Caryle Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **Stella Grady**
(b) Address **5600 Arsenal St.**

17. (a) **removal** (b) Date thereof **8-28-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Louis**

18. (a) Signature of funeral director **Russell Ind. Co**
(b) Address **2732 Vine St**

19. **AUG 27 1940** (b) **J. B. Buech**
(Date received from Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **0 Mo.** (b) County _____
(c) City or town **St. Louis** **21**
(If outside city or town limits write "RURAL")
Street No. **1419 Francis.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **24th**
year **1940** hour **5** minute **30** P. M.

21. I hereby certify that I attended the deceased from **7/5**
1940 to **8/24**, 19 **40**
that I last saw h. **er.** alive on **8/24**, 19 **40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary tuberculosis**

Due to _____ **23**
Due to _____

Other conditions **Intestinal tuberculosis**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy **as given above**

Duration _____
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) _____
(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 **Russell Maxwell** (M. D. or other) _____
Address **Isolation Hosp., St. Louis** Date signed **8/28/40**

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

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.....

William C. McDowell....., Registered Apprentice No.
working under my personal supervision.

Signed *William C. McDowell*

Licensed Embalmer No. *2114*

P. O. Address.....

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.