

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 VITAL RECORDS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33879

8576

Registration District No. 791

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

- (a) County _____
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer S. Phillips
(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)

3. (a) PRINT
FULL NAME ELiza Coleman3. (b) If veteran,
name war _____3. (c) Social Security
No. _____

4. Sex Female 5. Color or race Col 6. (a) Single, widowed, married,
divorced married
6. (b) Name of husband or wife Joe Coleman 6. (c) Age of husband or wife if
alive 49 years
Birth date of deceased Feb 17 1896
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
44 8 26 hr. mlp.

9. Birthplace Macon Miss
(City, town, or county) (State or foreign country)

10. Usual occupation Home Wife

11. Industry or business _____

MOTHER FATHER { 12. Name Jim Johnson
13. Birthplace Macon Miss
(City, town, or county) (State or foreign country)
14. Maiden name Marrah Williams
15. Birthplace Macon Miss
(City, town, or county) (State or foreign country)

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

(b) Address 2734 Bernard St.

17. (a) Burial (b) Date thereof Oct 18 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem

18. (a) Signature of funeral director H. W. Green

(b) Address 2915 Franklin Ave.

19. (a) OCT 17 1940 (b) J. F. Brudick
(Date received local registrar) (Signature of Registrar)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County St. Louis
(c) City or town St. Louis 22
(If outside city or town limits, write "RURAL")
(d) Street No. 2734 Bernard
(If rural, give location)
(e) No Foreign born, how long in U.S.A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 14
year 1940 hour 2 minute 15 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Granulosa
Chronic interstitial nephritis

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury 5

23. Signature W. H. Green (M. D. or other) _____
Address 2915 Franklin Ave. Date signed 10/18/40

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Licensed Embalmer No. 2963

P. O. Address 2915 Franklin

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.