

S. No. 2
M-5-42
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8181
State File No. _____
Registrar's No. 3007

ED APR 9 1943 18

1003

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo. 17 days
In this community 30 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis, (If outside city or town limits, write "RURAL")
(d) Street No. 802 1/2 Jefferson (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Albert Coleman
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or Race Negro 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 18, 1881
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 0 0 _____ hr. _____ min.

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

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER { 12. Name Albert Coleman
13. Birthplace Ark. (City, town, or county) (State or foreign country)
14. Maiden name Julia Coleman
15. Birthplace Ark. (City, town, or county) (State or foreign country)

16. (a) Informant Shirley M. Smith

(b) Address 2601 N. Whittier

17. (a) Autopsial Burial, cremation, or removal Date thereof 3-25-43
(b) Place: burial or cremation St. Louis, Mo.

18. (a) Signature of funeral director W. Richter

(b) Address 3500 Cutanda

19. (a) MAR 30 1943 (b) J. F. Brebeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 18,
year 1943 hour 11 minute 45 A. M.
21. I hereby certify that I attended the deceased from February
1, 1943 to March 18, 1943;
that I last saw him alive on March 18, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease
Chr. Nephritis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Duration
Unk.
Unk.

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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 _____
23. Signature S. E. Smith (M. D. or other)
Address 2601 Whittier Date signed 3/23/43

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

Signed.....

Licensed Embalmer No.....

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, fact should be so stated above.