

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

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10518**

FILED MAR 29 1943

Registration District No. **156**

Primary Registration District No. **2001**

Registrar's No. **152**

1. PLACE OF DEATH:

(a) County **Jasper**
(b) City or town **Joplin**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
521 N. Wall 4 Nursing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 mo.** (Specify whether

In this community
years, months or days

3. (a) PRINT FULL NAME **James Coleman**

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

4. Sex **Male** 5. Color or race **W** 6. (a) Single, widowed, married, divorced, **widowed**

6. (b) Name of husband or wife **No record** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **Sept. 9, 1863**
(Month) (Day) (Year)

8. AGE: Years **79** Months **6** Days **1** If less than one day **hr. min.**

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

10. Usual occupation **Common Laborer**

11. Industry or business

12. Name **No record** 9

13. Birthplace **No record** 9
(City, town, or county) (State or foreign country)

14. Maiden name **No record** 7

15. Birthplace **No record** 9
(City, town, or county) (State or foreign country)

16. (a) Informant **Health & Welfare Assoc.**

(b) Address **Joplin, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **3/10/43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Fairview Cem.**

18. (a) Signature of funeral director **Hurlbut Und. Co.**

(b) Address **Joplin, Mo.**

19. (a) **3-10-43** (Date received local registrar) (b) **Esther S. Scholter** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper** 49
(c) City or town **Joplin** 2
(If outside city or town limits, write "RURAL") 5
(d) Street No. **1334 Ohio** Last known Address
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **10**
year **1943** hour **6** minute **30** p. M.

21. I hereby certify that I attended the deceased from **Feb 20** 19 **43** to **Mar - 9** 19 **43**

that I last saw him alive on **March 9** 19 **43** and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive** Duration
Pneumonia

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) (c) Means of injury **0**

23. Signature **E. B. Coates** (M. D. or other)
Address **206 Grace St.** Date signed **3-10-43**

1204 (Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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.

Signature *Perry Schubert*

Licensed Embalmer No. *959*

P. O. Address *Japan Neo*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10078
Registrar's No. 102

Registration District No. 156 Primary Registration District No. 2001

1. PLACE OF DEATH:

(a) County Jasper Jasper
(b) City or town Jasper
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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 James Coleman

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

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 9 1863
(Month) (Day) (Year)

8. AGE: Years 79 Months 6 Days _____ (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry of business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day 10
year 1943 hour _____ minute _____ M.

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

Immediate cause of death Suppurative pneumonia

Due to Lobar pneumonia

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 CC Coats (M. D. or other) _____

Address Joplin Mo Date signed 4-30-50

SUPPLEMENTARY

MOTHER FATHER

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

