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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 1 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

187

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **807**

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: St. Louis City Hospital
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Three days
(Specify whether

In this community ?
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. 5564 Cabanne Ave.
(If rural, give location)

(e) Citizen of foreign country? ? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Nora Coleman

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased ?
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>68</u>	<u>--</u>	<u>--</u>	hr. min.

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

10. Usual occupation ?

11. Industry or business ?

MOTHER FATHER

12. Name James

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

14. Maiden name Fannie

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

16. (a) Informant M. Renard
(b) Address City Hospital, 1515 Lafayette

17. (a) _____ (b) Date thereof 1.27.44
(Month) (Day) (Year)

(c) Place burial or cremation City Crematory

18. (a) Signature of funeral director J. W. J. White
(b) Address City Hospital, 1515 Lafayette

19. (a) JAN 26 1944 (b) J. F. [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 30
year 1943 hour 7:50 minute P M.

21. I hereby certify that I attended the deceased from December 28 1943 to December 30 1943; that I last saw her alive on December 30 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia

Due to _____

Due to _____

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

Major findings: infection

Of operations none

Of autopsy same

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? _____

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

23. Signature: [Signature] M.D. or other _____
Address 1515 Lafayette Avenue Date signed 2/3/43

FLV (Licensed Embalmer's Statement on Reverse Side)

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.