

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED FEB 13 1945

Registration District No. 153 Primary Registration District No. 3127 Registrar's No. 3

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

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

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jasper 49
 (c) City or town Webb City
 (If outside city or town limits, write "RURAL") 16
 (d) Street No. _____
 (If rural, give location) 7
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____ 11

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

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month January day 4
 year 1945 hour 7 minute 30 P.M.
 21. I hereby certify that I attended the deceased from JAN 4TH
1945 to JAN 4TH 1945
 that I last saw him alive on JAN 4TH 1945
 and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W
 6. (a) Single, widowed, married, divorced P
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Jan 4 1945
 (Month) (Day) (Year)

Immediate cause of death PREMATURE BIRTH
 Duration _____

8. AGE: Years _____ Months _____ Days _____ If less than one day 6 hr. 40 min.
 9. Birthplace Webb City Mo
 (City, town, or county) (State or foreign country)

Due to _____
 Due to 159
 Other conditions (Include pregnancy within 3 months of death) _____

10. Usual occupation Infant
 11. Industry or business? _____
MOTHER FATHER
 12. Name Oral C. Coleman
 13. Birthplace Wesport Mo
 (City, town, or county) (State or foreign country)
 14. Maiden name Geneva May Rice
 15. Birthplace Scott Co Iowa
 (City, town, or county) (State or foreign country)

Major findings:
 Of operations _____
 Of autopsy _____
PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant Jacob O.C. Coleman
 (b) Address Webb City Mo
 17. (a) Burial (b) Date thereof 1/6/45
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mt Hope Cemetery
 18. (a) Signature of funeral director Hedger Lemis
 (b) Address Webb City Mo
 19. (a) Jan 6 1945 (b) Mrs. Lillie Lyle
 (Date received local registrar) (Registrar's signature)

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? _____ (a) Means of injury 2
 23. Signature C. M. Bruce (M. D. or other) DD
 Address CARTERSVILLE Mo Date signed 1-6-45

45-1-117

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 C W Hedge

Licensed Embalmer No. 2859

P. O. Address W. Ash City Mo

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.