

FILED FEB 28 1945

Registration District No. _____

Primary Registration District No. 90393

Registrar's No. 57

1. PLACE OF DEATH:
(a) County Monroe on Santa Fe
(b) City or town train no 20, marceline
(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) 1
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Ill (b) County Cook 999
(c) City or town Chicago 11
(If outside city or town limits, write "RURAL")
(d) Street No. 544 Indiana Ave
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME THOMAS COLEMAN
3. (b) If veteran, name war _____ 3. (c) Social Security No. 708-12-0607

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan. day 17
year 1945 hour 5 minute A.M.

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced 9
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: 2 months (Month) 29 (Day) 1909 (Year)

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

8. AGE: Years 50 Months _____ Days _____ If less than one day _____ hr. _____ min.

Immediate cause of death Lobar Pneumonia Duration 1
According to information given by friends on train.
Due to died on train # 20 Santa Fe
Due to R.R.

9. Birthplace Chicago Ill (City, town, or county) (State or foreign country)
10. Usual occupation Drawing car emp

Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: None 109
Of operations _____
Of autopsy Viewing remains

11. Industry or business Dep Drawing Unit
12. Name Unknown
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace _____ (City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Drawing car chef
(b) Address Chicago Ill
17. (a) Funeral (Burial, cremation, or removal) (b) Date thereof 1-29-45 (Month) (Day) (Year)
(c) Place: burial or cremation Chicago Illinois

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature Dale Bunch 3 (M. D. or other) Carson
Address Marceline Mo Date signed 1/18/45

18. (a) Signature of funeral director James M. Vaughn
(b) Address Marceline Mo
19. (a) 1-19-45 (Date received local registrar) (b) P. S. Vatusk M.D. (Registrar's signature)

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

MOTHER FATHER

MAR - 8 1945

FEB 16 1945

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.....

Blanche M. Langley

Licensed Embalmer No.....

1909

P. O. Address.....

Marseline M.

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. FebRegistration District No. 385Primary Registration District No. 3039Registrar's No. 51

1. PLACE OF DEATH: Linn-on Santa Fe Train
 (a) County Marion
 (b) City or town Train
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Excelsior on Train
 (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 Thomas Coleman
 3. (b) If veteran, name war.....
 3. (c) Social Security No. 708-12-0607

4. Sex M 5. Color or race B
 (b) Name of husband or wife Information not supplied
 6. (a) Single, widowed, married, divorced.....
 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased unk
 (Month) (Day) (Year)
 8. AGE: Years 50 Months Days If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 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) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) (Date received local registrar) (b) (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 Jan year 1945 hour 10 minute 30 M.

21. I hereby certify that I attended the deceased from 1945 to 1945 and that death occurred on the date and hour stated above. Immediate cause of death Myocardial infarction Duration.....

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.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTAL

S-2791