

S. No. 2
M-8-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13094

FILED MAY 12 1945

Registrar's No. 63

Registration District No. 529

Primary Registration District No. 5234

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

1. PLACE OF DEATH:

(a) County CASS

(b) City or town PECCIA, WEST PECULIAR TOWNSHIP
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 4 N.E. PECULIAR
(If not in hospital or institution, write street number or location)

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

In this community 26 YEARS
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CASS

(c) City or town COLEMAN
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME DELLA COLEMAN

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex FEMALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife ROBERT W. COLEMAN

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

7. Birth date of deceased JUNE 3 1866
(Month) (Day) (Year)

8. AGE: Years 78 Months 10 Days 29

If less than one day _____ hr. _____ min.

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

10. Usual occupation AT HOME

11. Industry or business _____

12. Name JOHN SANDOZ

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

14. Maiden name ROSENA LENZ

15. Birthplace ST LOUIS MO.
(City, town, or county) (State or foreign country)

16. (a) Informant SPENCER COLEMAN

(b) Address PECULIAR, MO.

17. (a) BURIAL (b) Date thereof MAY 3 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WING CEM., PECULIAR, MO.

18. (c) Signature of funeral director B. K. Simpson

(b) Address PECCIA, MO.

19. (a) MAY 5, 1945 (b) Margaret Toller
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 2
year 1945 hour 12 minute 30 A.M.

21. I hereby certify that I attended the deceased from MAY 11
1945 to MAY 2 1945
that I last saw her alive on MAY 2 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to Cerebral arteriosclerosis

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

Major findings: Of operations _____

Of autopsy _____

Duration 16 hrs

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 Walter V. Holbrook (M.D. or other) MD

Address PECCIA, MO. Date signed 5/3/45

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.....

A. R. George

Licensed Embalmer No.....

3645

P. O. Address.....

Sumner, 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: