

S. No. 2  
OM-8-43  
ev. 5-17-39  
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17563

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAY 16 1945

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 5787

Registrar's No. 32

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

1. PLACE OF DEATH:

(a) County Mississippi

(b) City or town Charleston (rural)  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: R#2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 17 Years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Sam Coleman

3. (b) If veteran, name war: \_\_\_\_\_

3. (c) Social Security No. 498-18-4372

4. Sex M 5. Color or race Negro

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

6. (b) Name of husband or wife Winnie Coleman

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased August 3rd 1892  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>8</u>	<u>24</u>	hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Dan Coleman

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

14. Maiden name N.K.

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

16. (a) Informant Winnie Coleman

(b) Address Charleston, Mo. R#2

17. (a) Burial (b) Date thereof 4/27/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Brook

18. (a) Signature of funeral director John G. Purnelle

(b) Address Charleston Mo

19. (a) 4/5/45 (b) Miss Lou Moore  
(Date registered local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Miss.

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

(d) Street No. R#2  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27 th  
year 1945 hour 8 minute P M.

21. I hereby certify that I attended the deceased from Mar 1 1945 to April 27 1945  
that I last saw him alive on April 27 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis 4 hrs

Due to Cardiac decompensation & arteriosclerosis 6 mos.

Due to \_\_\_\_\_

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy 94W

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

23. Signature T. P. Fenton (M.D. or Other)  
Address Wyatt, Mo Date signed 4/28/45

1257

RECEIVED

District Health Office No. 2,

District File Number 545.706

Date Filed 5-11-43

**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 *John F. Minnie*  
Licensed Embalmer No. 31851  
P. O. Address Charleston, 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.