

FILED AUG 11 1945

State File No.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6843

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

1. PLACE OF DEATH:

(a) County.....

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution DE PAUL HOSPITAL
(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)

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. 4845^A NORTHLAND AVE
(If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAME ELEANOR COLEMAN

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex F | 5. Color or race W

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

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

6. (c) Age of husband or wife if alive 17 years
(Day) (Year)

7. Birth date of deceased July 17 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

0-0-15 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name ERVIN E. COLEMAN

13. Birthplace DE SOTO MISSOURI
(City, town, or county) (State or foreign country)

14. Maiden name FRANCES DENNINGTON

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

16. (a) Informant MR. ERVIN E. COLEMAN

(b) Address 4845^A NORTHLAND AVE

17. (a) BURIAL (b) Date thereof 8-4-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation PARAGOULD, ARK

18. (a) Signature of funeral director SULLIVAN BROS

(b) Address 2849 N. E. CLAY AVE

19. (a) AUG 3 1945 (b) J. J. Brennan
(Date registered) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 26 year 1945 hour 8 minute 9 P. M.

21. I hereby certify that I attended the deceased from July 27, 1945 to Aug 2, 1945 that I last saw her alive on Aug 2, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death congenital heart disease

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

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)

Signature J. Wistra White (M. D. or other).....

Address 4350 22ND CLAY Date signed 8/3/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

J. WISTRA WHITE

Dr. Mowbride
Foster Bldg
Foster 3800
5416 Maple
70 1411

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 Robert L. Drinkman

Licensed Embalmer No. 3553

P. O. Address St Louis 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.