No. 2
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17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 13 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 27828

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 114

1. PLACE OF DEATH:
(a) County: Livingston
(b) City or town: Chillicothe
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1112 Clay Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community: 15 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri. (b) County: Livingston
(c) City or town: Chillicothe
(If outside city or town limits, write "RURAL")
(d) Street No.: 1112 Clay Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Bertha Smith Coulson
3. (b) If veteran, name war: No
3. (c) Social Security No.: None
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Dr. Richard Coulson
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Sept. (Month) 25th. (Day) 1859 (Year)
8. AGE: Years 85 Months 11 Days 6 If less than one day hr. min.
9. Birthplace: Wythville, (City, town, or county) Va. (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:
MOTHER FATHER
12. Name: James Colin Miller
13. Birthplace: Lynchburg, (City, town, or county) Virginia. (State or foreign country)
14. Maiden name: Mary Tompkins
15. Birthplace: Richmond, (City, town, or county) Virginia. (State or foreign country)
16. (a) Informant: Mrs Roy Welch
(b) Address: Chillicothe, Missouri.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9- 2-'45 (Month) (Day) (Year)
(c) Place: burial or cremation: Narrollton, Missouri
18. (a) Signature of funeral director: Norman Funeral Home
(b) Address: Chillicothe, Missouri.
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 30th. year 1945 hour 11:00 minute P.M.
21. I hereby certify that I attended the deceased from July 15, 1945 to Aug. 30, 1945 that I last saw her alive on Aug. 29th, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Thrombosis	6 weeks
Due to: Unknown	
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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: [illegible] (M. D.)
Address: Chillicothe, Mo. Date signed: 9-1-45

1514. (Licensed Embalmer's Statement on Reverse Side)

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

Frank L. Smiley, Registered Apprentice No.

working under my personal supervision.

Signed Frank L. Smiley

Licensed Embalmer No. 476

P. O. Address.

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.

No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 115

1. PLACE OF DEATH:

(a) County Livingston

(b) City or town Chillicothe
(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)

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

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

3. (a) PRINT FULL NAME Bertha S. Coulson

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 Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept (Month) 25 (Day) 1945 (Year)

8. AGE: Years 85 Months 11 Days 6 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) Aug 31. 1945 (Date received local registrar) (b) Frances B. Neill (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Aug 30 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

5-27828