S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 24 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33150

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1106

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Methodist Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 3 days (Specify whether years, months or days)
In this community: 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Buchanan 11
(c) City or town: St. Joseph 1
(If outside city or town limits, write "RURAL")
(d) Street No. (Parents at: 2526 Faraon) 7
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country:

3. (a) PRINT FULL NAME: Michael Perry Coleman
3. (b) If veteran, name war: No
3. (c) Social Security No.: None
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: October (Month) 9 (Day) 1945 (Year)

8. AGE: Years	Months	Days	If less than one day
0	0	3	hr. min.

9. Birthplace: St. Joseph (City, town, or county) Missouri (State or foreign country) 0
10. Usual occupation: None
11. Industry or business:
MOTHER FATHER
12. Name: Lt. Gearld Max Coleman
13. Birthplace: Granger (City, town, or county) Missouri (State or foreign country) 0
14. Maiden name: Mildred Perry
15. Birthplace: Maysville (City, town, or county) Missouri (State or foreign country) A
16. (a) Informant: Lt. Gearld M. Coleman
(b) Address: 2526 Faraon St., St. Joseph, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/12/1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Ashland Cemetery
18. (a) Signature of funeral director: Walter Meierhoffer
(b) Address: 1302 Faraon St., St. Joseph, Missouri
19. (a) 10/17-45 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: October day: 12th. year: 1945 hour: 9 minute: 10 A. M.
21. I hereby certify that I attended the deceased from 10-12, 1945, to 10-12-45; that I last saw him alive on 10-12-45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
asphyxia	
Due to: Birth injury?	
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: H. C. Petersen (M. D. or other)
Address: 6 & 4 Francis St. Joseph Date signed: 10-12-45

1420 (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 not embalmed ~~by me, or by~~ .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed Albert E. Harrington

Licensed Embalmer No. 3258 Mo.

P. O. Address St. Joseph, 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.