

S. No. 2
OM-5-43
v. 5-17-39
I X38671

37527

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED DEC 6 1945

Registration District No. 155

Primary Registration District No. 3127

Registrar's No. 108

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town West City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jasper County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 hours
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49
(c) City or town West City 0
(If outside city or town limits, write "RURAL")
(d) Street No. Central St 0
(If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

Walter Lee Coleman

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Infant
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased November 2, 1945
(Month) (Day) (Year)

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

9. Birthplace West City Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business

12. Name Walter Lee Coleman

13. Birthplace Leadman Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name Genevieve May

15. Birthplace Leadman Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Ora Coleman

(b) Address Leadman, Mo.

17. (a) Burial (b) Date thereof 11/5/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph

18. (a) Signature of funeral director Walter Lee Coleman

(b) Address West City, Mo.

19. (a) 11-5-45 (b) W. Lee Coleman MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 3
year 1945 hour 3:23 minute 4 M.
21. I hereby certify that I attended the deceased from BIRTH, NOV 2
1945 to NOV. 3, 1945
that I last saw him alive on NOV. 3, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death

ANOXIA

Due to FAILURE OF FORAMEN
Due to OVALE TO CLOSE
(PATENT DUCTUS ARTERIOSUS)

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) (e) Means of injury 2

23. Signature W. Lee Coleman (M. D. or other)

Address CARTERSVILLE MO Date signed 11-5-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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 *Richard Gray Lewis*

Licensed Embalmer No. *4405*

P. O. Address *Webb City 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.