

No. 2
12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27792

Registration District No. 217 Primary Registration District No. 3045-5787 State File No. _____ Registrar's No. 73

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:
1/2 mile so. of Charleston.
(If not in hospital or institution, write street number or location)
(d) Length of stay: 8 years (Specify whether
In this community 8 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri. (b) County Mississippi
(c) City or town Charleston Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 1/2 mile So. of Charleston.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Winnie Jones Coleman

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Sam Coleman, Dec'd 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased November 14, 1895
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 9 1 hr. min.

9. Birthplace Not Known Texas
(City, town, or county) (State or foreign country)

10. Usual occupation House-worker

11. Industry or business None

MOTHER FATHER { 12. Name Robert Coleman

13. Birthplace Not Known Arkansas
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Marjorie Logen

(b) Address Charleston, Missouri.

17. (a) Burial (b) Date thereof 8-16-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director. E. G. [Signature]

(b) Address Charleston, Missouri.

19. (a) 8-31-46 (b) Mrs. [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 15th
year 1946 hour 1:00 minute 15 AM.

21. I hereby certify that I attended the deceased from 1-6-1946 to 4-15-1946
that I last saw her alive on 4-15-1946
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease Duration 8 mos.

Due to Chronic Nephritis 10 mos.

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? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature W. A. [Signature] (M. D. or other) _____

Address 204 S. Doernst St Charleston, Mo dated 8-26-46

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

196

RECEIVED

District Health Office No. 2,

District File Number 946-1073

Date Filed 9-5-46

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 Edward E. Pennington

Licensed Embalmer No. 4164

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.