

No. 2
1/47
17-39
X

FILED AUG 15 1947
Registration District No. **318**

Primary Registration District No. **1003**

WRITE PLAINLY—USING 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**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... **3 WEEKS**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... **MO** (b) County..... **COO**
(c) City or town..... **ST. LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street No. **5300 CABANNE**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME..... **Sister JOSEPHA MARY COLEMAN**
3. (b) If veteran, name war..... 3. (c) Social Security No.....
4. Sex..... **Female** 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.....
7. Birth date of deceased..... **APRIL 25 1872**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month..... **AUG** day..... **3** year..... **1947** hour..... **2** minute..... **30 A.M.**
21. I hereby certify that I attended the deceased from..... **July 6, 1947** to..... 19.....; that I last saw her alive on..... **Aug 2, 1947** 19.....; and that death occurred on the date and hour stated above.

8. AGE: Years..... **75** Months..... **3** Days..... **8** If less than one day..... hr..... min.....

Immediate cause of death..... **Cerebral thrombosis**
Due to..... **arteriosclerotic process**
and hypertension
+ nephrosclerosis
Other conditions..... (Include pregnancy within 3 months of death)
Major findings: Of operations.....
Of autopsy.....

9. Birthplace..... **Ireland**
(City, town, or county) (State or foreign country)
10. Usual occupation..... **RELIGIOUS**
11. Industry or business.....
12. Name..... **JOHN COLEMAN**
13. Birthplace..... **IRELAND**
(City, town, or county) (State or foreign country)
14. Maiden name..... **ANNA CUNNINGHAM**
15. Birthplace..... **IRELAND**
(City, town, or county) (State or foreign country)
16. (a) Name..... **Sister VINCENT**
(b) Address..... **5300 CABANNE**
17. (a) **BURIAL** (b) Date thereof..... **AUG 5-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation..... **CALVARY**
18. (a) Signature of funeral director..... **William Kelly**
(b) Address..... **4386 Grand**
19. (a) **AUG 5 1947** (b) **J. Bredek**
(Date received local registrar) (Registrar's signature)

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?..... (Specify type of work)
23. Signature..... **Wayne O. Gorb** (M. D. or other)
Address..... **2739 N. Grand** Date signed..... **8-3-47**

Duration..... **1 week**
PHYSICIAN.....
Underline the cause of which death should be charged statistically.

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

James A. Lammer

Licensed Embalmer No. *4142*

P. O. Address *St. Louis*

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.

Registration District No. 318

Primary Registration District No. 1003

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(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:

(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)

3. (a) PRINT FULL NAME Joseph M. Coleman

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

4. Sex 7 5. Color of race w 6. (a) Single, widowed, married, divorced 5

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

7. Birth date of deceased April 25 1875
(Month) (Day) (Year)

8. AGE: Years 75 Months 3 Days 9 (if less than one day) hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

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) (Date received local registrar) (b) J. J. Bredeck (Registrar's signature)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

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) (e) Means of injury.....

23. Signature..... (M. D. or other)

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

SEP 2 1946

S-25408

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