

Registration District No. 319

Primary Registration District No. 6079

1. PLACE OF DEATH:

(a) County Ste. Genevieve
(b) City or town Ste. Genevieve Rural
(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.
In this community _____
years, months or days

3. (a) PRINT FULL NAME Margaret E. 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 Married /

6. (b) Name of husband or wife Norman E. Coleman 6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased March 15 1901
(Month) (Day) (Year)

8. AGE: Years 46 Months 4 Days 4
If less than one day hr. min.

9. Birthplace St. Francis County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Alfred Chilton

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

14. Maiden name Ellen Boon

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

16. (a) Informant Norman E Coleman

(b) Address Ste. Genevieve, Missouri

17. (a) Burial (b) Date thereof 22 July 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Farmington, Missouri

18. (c) Signature of funeral director Jerome J. Sloubin

(b) Address Ste. Genevieve, Missouri

19. (a) July 25-47 (b) Grace M. Hall
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ste. Genevieve
(c) City or town Ste. Genevieve Rural
(d) Street No. _____
(e) Citizen of foreign country? No
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19
year 1947 hour 9 minute 30 A. M.
June 15

21. I hereby certify that I attended the deceased from July 19 1945
er to July 19 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy
Duration 34 days

Due to Essential hypertension

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 Arthur E. Sawyer (M. D. or other) M.D.

Address Ste. Genevieve Mo Date signed 7-19-47

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

RECEIVED

District Health Officer No. 4

District File Number 847-1026

Date Filed 8-2-47

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 Jerome J. Stanton

Licensed Embalmer No. 3817

P. O. Address St. Charles, 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.