No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35609

FILED NOV 3 1947

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9765

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 Alexian Brothers Hospital
(If not in hospital or institution, write street, number or location)
(d) Length of stay: In hospital or institution 6 weeks (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2605 Olive Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Dr. Charles R. 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 Married
6. (b) Name of husband or wife Dorothy
6. (c) Age of husband or wife if alive 23 years
7. Birth date of deceased November (Month) 12th (Day) 1901 (Year)

8. AGE: Years 45 Months 11 Days 9 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Optometrist
11. Industry or business

FATHER
12. Name Ralph C. Coleman
13. Birthplace San Francisco (City, town, or county) Calif. (State or foreign country)

MOTHER
14. Maiden name Mae Anderson
15. Birthplace Mattoon (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Mae Coleman
(b) Address 3931 Childress, St. Louis, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/47 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Cemetery
18. (a) Signature of funeral director Wacker-Kelderle U.&L. Co.
(b) Address 3634 Gravois, St. Louis, Mo.
19. (a) OCT 21 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 21st year 1947 hour 7 minute 30 A. M.

21. I hereby certify that I attended the deceased from September 1946 to October 21, 1947 that I last saw him alive on 10-21-, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cirrhosis of liver	13 mo
Laennec's Cirrhosis	
Due to	
Due to	
Other conditions: Ascites (Include pregnancy within 3 months of death)	1 yr

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause of 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 D. D. Michael (M. D. or other) M.D.
Address 812 Olive Date signed 10/21/47

Jefferson City Printing Co.

(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 embalmed by me, or by.....

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

working under my personal supervision.

Signed.....

Licensed Embalmer No. 2645

P. O. Address.....

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.