

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36227**

FILED DEC 1 1949

BIRTH NO.		REG. DIST. NO. 10	PRIMARY REG. DIST. NO. 5036	Registrar's No. 196
1. PLACE OF DEATH a. COUNTY Andrew		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission). a. STATE Illinois b. COUNTY Sangamon		
b. CITY (If outside corporate limits, write RURAL and give township) Central Wilson		c. LENGTH OF STAY (in this place) 1 1/4 MID	c. CITY (If outside corporate limits, write RURAL and give township) Springfield, Ill. 999	
d. FULL NAME OF HOSPITAL OR INSTITUTION Rural Wilson Trp		d. STREET ADDRESS (If rural, give location) 11 1/2		
3. NAME OF DECEASED (Type or Print) ELIZABETH		a. (First)	b. (Middle) COLEMAN	c. (Last)
4. DATE OF DEATH NOV-19-1949		5. SEX Female		6. COLOR OF RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH Aug-15-1885		9. AGE (In years last birthday) 64
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wales - 4
12. CITIZEN OF WHAT COUNTRY? Wales		13a. FATHER'S NAME George Rees		
13b. MOTHER'S MAIDEN NAME Sarah Brickett		14. NAME OF HUSBAND OR WIFE (If deceased) Leonidas Coleman		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mrs Frank Poole
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart disease		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Acute myocardial degeneration		3 days
		DUE TO (c)		
		11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		142X
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Nov. 3, 1949 to Nov. 19, 1949 , that I last saw the deceased alive on Nov. 19, 1949 , and that death occurred at 7:30 p.m. , from the causes and on the date stated above.				
23a. SIGNATURE R. P. Rabbit		(Degree or title)		23b. ADDRESS Centerville, mo
23c. DATE SIGNED 11-20-49				
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Nov 20 1949		24c. NAME OF CEMETERY OR CREMATORY Dorridge
				24d. LOCATION (City, town, or county) (State) Springfield Ill
DATE REC'D BY LOCAL REG. Nov 20-1949		REGISTRAR'S SIGNATURE Blanche Neely		25. FUNERAL DIRECTOR'S SIGNATURE Grace Jensen
				ADDRESS Centerville, mo

(Licensed Embalmer's Statement on Reverse Side)

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

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RECEIVED NOV 28 1949
District Health Officer No. 10
District File Number ~~11-49-1994~~ NOV 28 1949
Date Filed _____

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Frank Jensen

Licensed Embalmer No. 4270

P. O. Address Centerville 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.