

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**19291**

**FILED JUN 4 1953**

State File No. ....

**318**

**1003**

**5040**

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| BIRTH NO. _____  |  | REG. DIST. NO. _____   |  | PRIMARY REG. DIST. NO. _____  |  | Registrar's No. _____  |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY _____  |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis</b>  |  | c. LENGTH OF STAY (In this place) <b>Life</b>  |  | c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>   |  | 22590  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G Phillips Hospital</b>   |  |  |  | d. STREET ADDRESS (If rural, give location) <b>818 N.15th St.</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or Print) a. (First) <b>Arthur</b>   |  | b. (Middle) _____  |  | c. (Last) <b>Coleman</b>  |  | 4. DATE OF DEATH (Month) (Day) (Year) <b>May 10 1953</b>                         |  |
| 5. SEX <b>Male 2</b>   |  | 6. COLOR OR RACE <b>Colored</b>  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow 2</b>   |  | 8. DATE OF BIRTH <b>August 27, 1869</b>  |  |
| 9. AGE (In years last birthday) <b>83</b>  |  | IF UNDER 1 YEAR Months _____ Days _____  |  | IF UNDER 24 HRS. Hours _____ Min. _____   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY _____        |   |  | 11. BIRTHPLACE (State or foreign country) <b>Missouri 0</b>                      |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>  |  |  |  |   |  |  |  |
| 13a. FATHER'S NAME <b>Will Coleman</b>   |  |  | 13b. MOTHER'S MAIDEN NAME <b>Sylvia Carter</b> |   |  | 14. NAME OF HUSBAND OR WIFE <b>Unknown</b>                                       |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>Unknown</b>  |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Unknown</b>                          |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Elizabeth Rhodes, 2601 N Whittier St</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  | MEDICAL CERTIFICATION   |  |  |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Probable G. I. Malignancy</b><br><br>ANTECEDENT CAUSES<br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) <b>Malnutrition</b> |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>  |  |  |  |
|  |  |  |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |  |
|  |  |  |  |   |  |  |  |
| 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? _____ 159X   |  |  |  |
| 22. I hereby certify that I attended the deceased from <b>5-6</b> , 19 <b>53</b> , to <b>5-10</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>5-10</b> , 19 <b>53</b> , and that death occurred at <b>5:40a</b> m., from the causes and on the date stated above.  |  |  |  |   |  |  |  |
| 23a. SIGNATURE (Degree or title) <b>Carl Bill Smith M. D. J.</b>   |  |  |  | 23b. ADDRESS <b>2601 N Whittier St</b>  |  | 23c. DATE SIGNED <b>5-15-53</b>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) _____  |  | 24b. DATE <b>5-30-53</b>   |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>  |  | 24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>              |  |
| DATE REC'D BY LOCAL REG. <b>MAY 19 1953</b>  |  | REGISTRAR'S SIGNATURE <b>Carl Bill Smith MO</b>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Rowland Mortuary Service</b>  |  |  |  |

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

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**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.....

Licensed Embalmer No. ....

P. O. Address.....

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.