

FILED NOV 25 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38110
State File No. 9867
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN Webster Groves d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		e. STREET ADDRESS (If rural, give location) 5 Nagel Court	

3. NAME OF DECEASED (Type or Print)	a. (First) Clifford	b. (Middle) John	c. (Last) Coleman	4. DATE OF DEATH (Month) (Day) (Year) November 12, 1955
-------------------------------------	----------------------------	-------------------------	--------------------------	--

5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1-28-1887	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours	IF UNDER 15 MIN. Min.
-----------------	---------------------------	---	-----------------------------------	---	------------------------	-----------------------	-----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Acct. Retired	10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (City and State or Foreign Country) Cleveland Ohio	12. CITIZEN OF WHAT COUNTRY? USA
--	---	--	---

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME: Frances Whitney	14. NAME OF HUSBAND OR WIFE LaVernia Coleman
-----------------------------------	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes	16. SOCIAL SECURITY NO. W.W. # 1 284-10-1653	17. INFORMANT'S SIGNATURE OR NAME Mrs. C.J. Coleman	ADDRESS 5 Nagel Ct.
---	---	--	----------------------------

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Circulatory Failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral-Vascular Accident DUE TO (c) Arteriosclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypostatic Pneumonia			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 33-1X	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 **11-9-** 19 **55**, to **11-12-** 19 **55**, that I last saw the deceased alive on **11-12**, 19 **55**, and that death occurred at **11:15am** from the causes and on the date stated above.

23a. SIGNATURE [Signature]	(Degree or title) M.D.	23b. ADDRESS 1515 Lafayette	23c. DATE SIGNED 11/12/55
-----------------------------------	-------------------------------	------------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 11-13-1955	24c. NAME OF CEMETERY OR CREMATORY Knollwood Cemetery	24d. LOCATION (City, town, or county) (State) Cleveland Ohio.
--	-----------------------------	--	--

DATE REC'D BY LOCAL REG. NOV 14 1955	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS [Address]
---	--	---	--------------------------

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

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.....
Signature of Student Embalmer

Signed *Neville B. Frohwitter*.....

Licensed Embalmer No. *369*.....
P. O. Address *15 W. Locust*.....

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 embalmed by a **STUDENT**, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.