

FILED JAN 26 1956

STANDARD CERTIFICATE OF DEATH

2652
State File No. 486
Registrar's No.

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY OR TOWN St. Louis	c. LENGTH OF STAY (In this place) 25	c. CITY OR TOWN St. Louis	d. Is Residence within limits of city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		STREET ADDRESS (If rural, give location) 27 2231 Carr	

3. NAME OF DECEASED a. (First) Willie b. (Middle) c. (Last) Coleman			4. DATE OF DEATH (Month) (Day) (Year) 1 10 56		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Separated	8. DATE OF BIRTH 7-6-1900	9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Albert Coleman	13b. MOTHER'S MAIDEN NAME Lillie Phillips	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Hospital Records ADDRESS
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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 Undt.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Renal Failure with Uremia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebrovascular Accident			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 592x	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)	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 **12-27**, 19**55**, to **1-10**, 19**56**, that I last saw the deceased alive on **1-10**, 19**56**, and that death occurred at **10:52 Pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edw. B. Williams M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 1-11-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Jan 16/56	24c. NAME OF CEMETERY OR CREMATORY Oak Oak Cem	24d. LOCATION (City, town, or county) (State) St Louis Mo
DATE REC'D BY LOCAL REG. JAN 16 1956	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. A. Heller 4214 Delmar	

WRITE PLAINLY—USING UNFADING 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 *F. A. Green*.....

Licensed Embalmer No. *2963*.....

P. O. Address *4214 Delmar*.....

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.