

FILED DEC 6 - 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **39982**BIRTH NO. **99247-56** REG. DIST. NO. **319** PRIMARY REG. DIST. NO. **541** Registrar's No. **2741**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY OR TOWN <b>Clayton</b>		c. CITY OR TOWN <b>Kinloch 7091</b>	
c. LENGTH OF STAY (in this place) <b>2 hrs</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis County Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>1140 Lix,</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Baby Boy</b> b. (Middle) <b>Coleman</b> c. (Last) <b>Coleman</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 17, 1956</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>11-17-56</b>
9. AGE (In years last birthday) <b>7</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b>	IF UNDER 24 HRS. Hours <b>7</b> Min. <b>7</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Clayton, Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Arvellus Coleman</b>	
13b. MOTHER'S MAIDEN NAME <b>Mattie Jackson</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>County Hosp - Clayton Mo.</b>		ADDRESS <b>Clayton Mo.</b>	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Atelectasis of Lung</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 hr</b> ANTECEDENT CAUSES DUE TO (b) <b>Immaturity</b> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS 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 checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>7625</b>	
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)		<b>7625</b>	
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 <b>11-17-</b> , 19 <b>56</b> , to <b>11-17-56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>11-17-56</b> , 19 <b>56</b> , and that death occurred at <b>7:15 a m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Herbert B. Donk M.D.</b>		23b. ADDRESS <b>601 S. Brentwood, Clayton 5, Mo.</b>	
23c. DATE SIGNED <b>11-17-56</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		24b. DATE <b>11-21-56</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>St. Louis Crematory</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>11-21-56</b>		REGISTRAR'S SIGNATURE <b>Herbert B. Donk M.D.</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>St. Louis County Hosp - Clayton Mo.</b>		ADDRESS <b>Clayton Mo.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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..... Signed.....

Signature of Student Embalmer

Licensed Embalmer No.....

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