

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10081

FILED MAR 27 1957

STATE FILE NUMBER  
2317

Registration District No. **318** Primary Registration District No. **1003**

Health,  
Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4036 Sullivan</b>				Length of stay in lb <b>2 2/11</b>		d. STREET ADDRESS (If outside, give location) <b>2808 Thomas St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Mary Coleman</b>				4. DATE OF DEATH Month <b>3</b> Day <b>6</b> Year <b>57</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-8-1894</b>	9. AGE (In years last birthday) <b>62</b>		IF UNDER 1 YEAR Months <b>9</b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (City and state or country) <b>Georgia /</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Nicholas Ritchie</b>				14. MOTHER'S MAIDEN NAME <b>Amida Ritchie</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>Unk.</b>		17. INFORMANT Address <b>Mary Crook 2808 Thomas St/</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular thrombosis</b> <b>Pneumonia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Pneumonia</b> DUE TO (c) <b>332x</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>4 days</b>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> Month <b></b> Day <b></b> Year <b></b> a. m. <b></b> p. m. <b></b>								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <b>Mar. 1957</b>		COUNTY <b>3-5-57</b>	STATE <b>5-1957</b>	
21. I attended the deceased from <b>Feb. 1957</b> to <b>March 1957</b> and last saw her/him alive on <b>March 5-1957</b> Death occurred at <b>6:30 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>J. W. Hoard</b> (Degree or title) <b>MO.</b>				22b. ADDRESS <b>129 E. Kirkham</b>		22c. DATE SIGNED <b>3-6-57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>3-11-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Co., Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>J. McClendon 4535 Washington</b>				25. DATE RECD. BY LOCAL REG. <b>MAR 8 '57</b>		26. REGISTRAR'S SIGNATURE <b>J. Earl Smith, m.d.</b>		

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 *John R Cunningham*.....

Licensed Embalmer No. *447*

P. O. Address *4700 Nam*

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.