

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-031319

STATE FILE NUMBER

FILED AUG 18 1958 Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2111

1. PLACE OF DEATH va. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Cook</b>		
* b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Wellston - Rural</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Chicago</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>St. Vincent's Hosp.</b>		Length of stay in lb <b>3 yrs. 10 mos.</b>	d. STREET ADDRESS (If outside, give location) <b>8111 Manistee Avenue</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Eugene J. Coleman</b>			4. DATE OF DEATH Month Day Year <b>Aug. 12, 1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</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>Feb. 11, 1890</b>	9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR Months Days <b>6</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant Auditor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	11. BIRTHPLACE (City and state or country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>(U) Eugene Coleman</b>		13b. MOTHER'S MAIDEN NAME <b>Kathleen O' Shea</b>		14. NAME OF HUSBAND OR WIFE <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>Mrs. Marjorie Shea, dgtr. Chicago, Ill.</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>Broncho Pneumonia, bilateral</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. } DUE TO (b) _____ DUE TO (c) <b>Chronic Br. Syndrome Asso. with Cerebral Arterio-</b>					<b>4 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. <b>arteriosclerosis</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) <b>334X</b>		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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		COUNTY STATE
21. I attended the deceased from <b>11-2-54</b> , to <b>8-12-58</b> and last saw <sup>BEK</sup> him alive on <b>8-12-58</b> Death occurred at <b>8:10 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>[Signature]</i>		22b. ADDRESS <b>7301 St. Charles Rock Rd.</b>		22c. DATE SIGNED <b>8/12/58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>8/13/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Evergreen Park, Ill.</b>
24. FUNERAL DIRECTOR <i>[Signature]</i>		ADDRESS <b>7267 Natural Bridge</b>		25. DATE RECD. BY LOCAL REG. <b>8-13-58</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *James A. Lemme* .....

..... Licensed Embalmer No. *4142* .....

P. O. Address *St. Louis* .....

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.