

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019050  
STATE FILE NUMBER  
Registration District No. 2  
Primary Registration District No. 4590

FILED MAY 22 1959

300  
-57

7 2.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u><br>b. COUNTY  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <u>St. Louis</u><br>Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |                                  | c. CITY<br>OR<br>TOWN <u>St. Louis</u><br>Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION <u>4211 Botanical Ave.</u><br>Length of stay in 1b  |                                  | d. STREET<br>ADDRESS<br><u>4211 Botanical Ave.</u><br>(If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><u>WINIFRED V. COLEMAN</u>   |                                  |  | 4. DATE<br>OF<br>DEATH<br>Month Day Year<br><u>May 9 1959</u>            |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><u>Feb. 22, 1875</u>                                 |
| 9. AGE (In years<br>last birthday)<br><u>84</u>   |                                  | 10. UNDER 1 YEAR<br>Months Days Hours Min.   | 11. UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><u>Housework</u>  |                                  | 10b. KIND OF BUSINESS OR<br>INDUSTRY<br><u>At Home</u>   | 11. BIRTHPLACE (City and state or country)<br><u>Scranton, Pa.</u>       |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                                  | 13a. FATHER'S NAME<br><u>Patrick Karney</u>  |  |
| 13b. MOTHER'S MAIDEN NAME<br><u>Margaret Desmond</u>  |                                  | 14. NAME OF HUSBAND OR WIFE<br><u>Late Thomas B. Coleman</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give year or dates of service)<br><u>No None</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>   | 17. INFORMANT<br>Address<br><u>Thomas Coleman 7030 Edison Ave.</u>       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>Conditions, if any, } DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u><br>which gave rise to }<br>above cause (a), }<br>stating the under- }<br>lying cause last. } DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Diabetes mellitus</u> |                                  |  | INTERVAL BETWEEN<br>ONSET AND DEATH<br><u>78 hours</u><br><u>unknown</u> |
| 19. WAS AUTOPSY<br>PERFORMED?<br>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.)  |                                  | 20c. TIME OF<br>INJURY<br>Hour Month, Day, Year<br>a.m.<br>p.m.  |  |
| 20d. INJURY OCCURRED<br>WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>WORK AT WORK  |                                  | 20e. PLACE OF INJURY (e.g., in or about home,<br>farm, factory, street, office bldg., etc.)  |  |
| 20f. CITY, TOWN, OR LOCATION<br>COUNTY STATE  |                                  | 21. I attended the deceased from <u>2 Aug 59</u> to <u>9 MAY 59</u> and last saw her <sup>her</sup> <sub>him</sub> alive on <u>8 MAY 59</u><br>Death occurred at <u>9:25 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. |  |
| 22a. SIGNATURE<br>(Degree or title)<br><u>John F. McLean M.D.</u>   |                                  | 22b. ADDRESS<br><u>4401 Hampton</u>  |  |
| 22c. DATE SIGNED<br><u>11 MAY 59</u>  |                                  | 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><u>Burial</u>  |  |
| 23b. DATE<br><u>May 12, 1959</u>  |                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Calvary Cemetery</u>  |  |
| 23d. LOCATION (City, town, or county)<br><u>St. Louis, Mo.</u>  |                                  | 24. FUNERAL DIRECTOR<br>ADDRESS<br><u>Kriegshausler 4228 S. Kingshighway</u>   |  |
| 25. DATE RECD. BY LOCAL REG.<br><u>MAY 11 '59</u>   |                                  | 26. REGISTRAR'S SIGNATURE<br><u>Earl Smith, M.D.</u>   |  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

*ms*

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 *Edwin A. Mc Nemeth* .....

Licensed Embalmer No. *3024* .....

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.