

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025692

FILED VS JUL 21 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. 559V Registrar's No. 100

STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>JEFFERSON</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JOACHIM TWP.</u>		a. STATE <u>Mo</u>		b. COUNTY <u>JEFFERSON</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>JEFF MEMORIAL Hosp</u>		Length of stay in lb <u>1wk</u>		c. CITY OR TOWN <u>DE SOTO</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>507 CEDAR</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>SARAH</u>		Middle <u>ANN</u>		Last <u>COLEMAN</u>		Month <u>JULY</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 4, 1881</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR		IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and state or country) <u>OLD MINES, MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>PAUL BOURISAW</u>		13b. MOTHER'S MAIDEN NAME <u>ROSALIE VILMER</u>		14. NAME OF HUSBAND OR WIFE <u>JOSEPH A. COLEMAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>JOSEPH A. COLEMAN DE SOTO, MO</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>							<u>June 28, 59</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>advanced Gen. arterio-sclerosis</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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.)					
20c. TIME OF INJURY. Hour _____ a.m. _____ p.m. Month, Day, Year _____							
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		COUNTY	STATE
21. I attended the deceased from <u>Aug 10, 1954</u> to <u>July 7, 59</u> and last saw her alive on <u>July 7, 59</u> . Death occurred at <u>402p</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Paul V. Hoffmeyer MD</u>				22b. ADDRESS <u>De Soto, Mo.</u>		22c. DATE SIGNED <u>7-9-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>7/10/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>		23d. LOCATION (City, town, or county) (State) <u>DE SOTO MO</u>		
24. FUNERAL DIRECTOR ADDRESS <u>MAHN Funeral Home De Soto, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>7/10/59</u>		26. REGISTRAR'S SIGNATURE <u>John A. Stoll Deputy</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 18 1954

Karl V. McKinstry, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Gerald J. Mahan

Licensed Embalmer No. 4975

P. O. Address De Soto, 1

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.