

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-025967

STATE FILE NUMBER

FILED VS AUG 7 1959

Registration District No. 209 Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Marion</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Marion</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Philadelphia (Union)</b>		c. CITY OR TOWN <b>Philadelphia</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Rural Route 1</b>		d. STREET ADDRESS (If outside, give location) <b>Rural Routel</b>	
3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>Luella</b> Last <b>Coleman</b>		4. DATE OF DEATH Month <b>July</b> Day <b>10</b> Year <b>1959</b>	
5. SEX <b>Female</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>June 22, 1878</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>Farm</b>	11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>
13a. FATHER'S NAME <b>John Raplee</b>		13b. MOTHER'S MAIDEN NAME <b>Amanda Gady</b>	14. NAME OF HUSBAND OR WIFE <b>Giles Coleman</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 <b>Helen Coleman, Philadelphia, Mo.</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>Hypostatic Pneumonia</b> DUE TO (b) <b>Elemental hypersthenia</b> DUE TO (c) <b>Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
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.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>May 1, 1959</b> to <b>July 10, 1959</b> and last saw her alive on <b>July 6, 1959</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>G. W. Moulton M.D.</b>		22b. ADDRESS <b>Shelbyville Mo</b>	22c. DATE SIGNED <b>7-14-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 13, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Coleman Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Philadelphia, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Feaster-Garner, Philadelphia, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>7-15-59</b>	26. REGISTRAR'S SIGNATURE <b>Dr. E. M. Lucke</b> <b>By Viola Greer, Deputy</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

**RECEIVED** AUG 5 1950  
**MARION CO. HEALTH DEPT.**  
**DATE FILED** AUG 5 1950

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 *Harold Turner* .....

Licensed Embalmer No. 3720  
P. O. Address *Marion City, Ind.*

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.