

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-041685**

**FILED VS. NOV 3 0 1959**

**210579**

STATE FILE NUMBER

UNDECEASED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>25 yrs.</b>		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>4256 West Pine</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4256 West Pine</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DORA</b> Middle <b>L.</b> Last <b>COLEMAN</b>				4. DATE OF DEATH Month <b>November</b> Day <b>13</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>2/18/98</b>	9. AGE (last birthday) <b>61 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleswoman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Clothing</b>		11. BIRTHPLACE (City and state or country) <b>Lookingglass, Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Henry Rieken</b>			13b. MOTHER'S MAIDEN NAME <b>Margaret Schardon</b>			14. NAME OF HUSBAND OR WIFE <b>William 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.		17. INFORMANT Address <b>Mrs. J. C. Bruegger, 4142 Hartford</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>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral hemorrhage</b> DUE TO (c) <b>420.0</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>8 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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 <b>July 1958</b> to <b>11/13/59</b> and last saw her alive on <b>11/13/59</b> . Death occurred at <b>10:00 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Charles C. Harris MD</b>				22b. ADDRESS <b>5298<sup>th</sup> Payne</b>		22c. DATE SIGNED <b>11/16/59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Nov. 17, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>College Hill Cemetery</b>		23d. LOCATION (City, town, or county) <b>Lebanon, Illinois</b>		(State)	
24. FUNERAL DIRECTOR ADDRESS <b>Beiderwieden F.H.Inc, 1936 St. Louis</b>				25. DATE RECD. BY LOCAL REG. <b>NOV 17 1959</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b> <i>mjs</i>		

DOCUMENT

MEDICAL CERTIFICATION

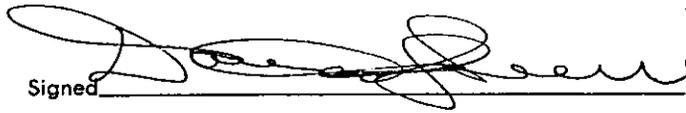
BY AFFIDAVIT OF

1-3-6:30-10

**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 

Licensed Embalmer No. 4520

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.