

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

-60-034260

FILED VS SEP 23 1960

STATE FILE NUMBER

Registration District No. 86 Primary Registration District No. 4149 Registrar's No. 22-1966

S. 300  
v. 1-57  
96

1. PLACE OF DEATH a. COUNTY <u>Crawford</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cuba</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Leasburg</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Senior Citizens Home</u>		Length of stay in lb <u>2 1/2 mos</u>	d. STREET ADDRESS (If outside, give location) <u>NONE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Dora</u> Middle <u>Belle</u> Last <u>Coleman</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>14</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 31 1870</u>	9. AGE (In years last birthday) <u>90</u>	IF UNDER 1 YEAR Months <u>13</u> Days <u></u> Hours <u></u> Min. <u></u>
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>Cassonade Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>W. Samuel Blair</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Carwile</u>		14. NAME OF HUSBAND <u>John R. Coleman Dead.</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>Mrs Flossie Avery Cuba, Mo</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral Arteriosclerosis</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) <u>331X</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease</u>					
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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>					
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>Sept. 1958</u> to <u>Sept. 14, 1960</u> and last saw her <u>him</u> alive on <u>Sept. 13, 1960</u> 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) <u>Frank A. Elders, M.D.</u>			22b. ADDRESS <u>Cuba, Mo.</u>		22c. DATE SIGNED <u>9-14-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-16-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Liberty</u>		23d. LOCATION (City, town, or county) (State) <u>Steelville Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Norman E. Hoener Cuba, Mo</u>			25. DATE RECD. BY LOCAL REG. <u>9-16-1960</u>	26. REGISTRAR'S SIGNATURE <u>Paul J. Shanahan</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 *Norman R. Spencer*  
Licensed Embalmer No. *4673*  
P. O. Address *Quincy, Mo*

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.