

Registration District No. 201 Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH: **3**

(a) County St. Louis Mo

(b) City or town St. Louis Mo

(c) Name of hospital or institution: Gr Route City Hospital

(d) Length of stay: In hospital or institution \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED: **1**

(a) State Mo (b) County \_\_\_\_\_

(c) City or town St Louis 25

(d) Street No. 1112 # O Fallon

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Nellie Coleman 455

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 2 year 1939 hour 6 minute 45 A M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

8. AGE: Years abt 62 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace: \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Unknown

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

Immediate cause of death \_\_\_\_\_

Due to Chronic Myocardites

Due to Chronic Interstitial Nephritis

Other conditions \_\_\_\_\_ (include pregnancy within 3 months of death)

16. (a) Informant's own signature Tom Lancken - P

(b) Address 4409 Castelman

17. (a) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof 12-14-39

(c) Place: burial or cremation Washington

18. (a) Signature of funeral director W. Richter

(b) Address 3300 Rutger

19. (a) DEC 28 1939 (b) \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 4

23. Signature J. M. Deane (M. D. or other) \_\_\_\_\_

Address Deputy Coroner Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

---

---

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, above space should be left blank.**

