

JAN 12 1940

791

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 42033

Registration District No. 1000

Primary Registration District No.

Registrar's No. 11156

1. PLACE OF DEATH: 1000

(a) County \_\_\_\_\_

(b) City or town St. Louis, Mo.

(c) Name of hospital or institution: St. John's Hospital

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

In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Warren

(c) City or town Jonesburg

(d) Street No. \_\_\_\_\_

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

3. (a) PRINT FULL NAME Henry Wade Coleman 455

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Oct. 8 1898

8. AGE: Years 41 Months 2 Days 18 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Jonesburg Missouri

10. Usual occupation Farmer

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

12. Name Skelton Coleman

13. Birthplace Henry Co. Virginia

14. Maiden name Frances Cullom

15. Birthplace Warren Co. Missouri

16. (a) Informant Robert Coleman

(b) Address Jonesburg, Mo.

17. (a) Removal (b) Date thereof 12/28/39

(c) Place: burial or cremation Jonesburg, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) DEC 28 1939 (b) J. B. Bledsoe

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 26<sup>th</sup> year 1939 hour 3 minute 00 P.M.

21. I hereby certify that I attended the deceased from Dec 12<sup>th</sup> 1939 to Dec 26<sup>th</sup> 1939; that I last saw him alive on Dec 26<sup>th</sup> 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Gastric hemorrhage  
gastric ulcer

Other conditions Cellulitis abdominal wall

Major findings: Perforated gastric ulcer  
Of operations \_\_\_\_\_  
Of autopsy no autopsy

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? \_\_\_\_\_  
(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 \_\_\_\_\_  
23. Signature W. J. Gallagher (M. D. or other) M.D.  
Address 634 N. Grand Date signed 12/27/39

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

**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.**

*No Embalmed*