

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County Jackson **1**  
(b) City or town Kansas  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Farmount Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days 11/18

3. (a) PRINT FULL NAME

Robert Coleman

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 \_\_\_\_\_

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

7. Birth date of deceased Jan 25 1940  
(Month) (Day) (Year)

8. AGE:

Years \_\_\_\_\_

Months \_\_\_\_\_

Days \_\_\_\_\_

If less than one day

11 hr. \_\_\_\_\_ min.

9. Birthplace

Kansas City Mo

(City, town, or county)

(State or foreign country)

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER  
12. Name Ralph M. Coleman  
13. Birthplace Crooksville Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name Priscilla Bartles  
15. Birthplace Prescott Kansas  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ralph M. Coleman

(b) Address 1817 Brownell

17. (a) Buried (b) Date thereof Jan 26-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Prescott KS

18. (a) Signature of funeral director Pharmacia Bros

(b) Address 15 C. MO

19. (a) Jan 26, 1940 (b) McLaurin  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson  
(c) City or town Kansas  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1817 Brownell  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 25 day 25  
year 1940 hour 9:00 minute 0 M.

21. I hereby certify that I attended the deceased from Jan 25, 1940 to Jan 25, 1940  
that I last saw him alive on Jan 25, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Blw Baby Duration \_\_\_\_\_  
15/18

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings: Of operations none

Of autopsy no

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 \_\_\_\_\_

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

Address 2418 Northland Date signed 1-26-40

WHILE FILLING IN USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

I-131511

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.

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**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.**