

Mayfield **821**
Registration District No.

Primary Registration District No. **4553**

Registrar's No.

06
11
2
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) - County. **Scott**
(b) City or town. **Sikeston**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **2**
(Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME **Ruben S. Coleman**

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

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **M**

6. (b) Name of husband or wife **Ida Coleman** 6. (c) Age of husband or wife if alive **57** years

7. Birth date of deceased. **2** / **17** / **1878**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 **7** **7** hr. min.

9. Birthplace **Sikeston Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Trucker**

11. Industry or business

12. Name **Unknown**
13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant **Christina Lowe**

(b) Address **Sikeston Mo.**

17. (a) **Burial** (b) Date thereof **9/25/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sikeston**

18. (a) Signature of funeral director **John A. ...**

(b) Address **Sikeston Mo.**

19. (a) **10-7-1940** (b) **John A. ...**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Scott**
(c) City or town **Sikeston Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9** day **24**
year **1940** hour **5** minute **30** a.m.

21. I hereby certify that I attended the deceased from **Aug 1**, 1940 to **Sept 24**, 1940
that I last saw him alive on **Sept 23**, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death **Curvature of spine**

Due to _____
Due to **46**
Other conditions (include pregnancy within 8 months of death)

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) **me**
(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?

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While at work? _____ (Specify type of place) (a) Means of injury _____

23. Signature **John A. ...** (M. D. or other) _____
Address **Sikeston Mo.** Date signed **9/25/40**

RECEIVED

District Health Officer No. 2

District File Number 1040-1347

Date Filed 10/10/30

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 *John A. Clinton*.....

Licensed Embalmer No. 2941

P. O. Address *Shelton, Md.*

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.