

APR 7 1944  
Registration District No. 566

Primary Registration District No. 3030

Registrar's No. 33

1. PLACE OF DEATH:

(a) County Mississippi  
(b) City or town CHARLESTON  
(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 \_\_\_\_\_  
(Specify whether  
In this community 21 YRS 1 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi  
(c) City or town CHARLESTON  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0 (If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME JOHN ELIJAH COLEMAN

3. (b) If veteran, name war No 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race COLOR 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife EMMA COLEMAN 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased (Month) (Day) (Year) 1874

8. AGE: Years 77 Months 0 Days 6 If less than one day hr. min.

9. Birthplace JACKSON Mississippi  
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business RETIRED

MOTHER FATHER

12. Name NOT KNOWN  
13. Birthplace NOT KNOWN 9  
(City, town, or county) (State or foreign country)  
14. Maiden name NOT KNOWN  
15. Birthplace NOT KNOWN 9  
(City, town, or county) (State or foreign country)

16. (a) Informant LEMUEL CASHSHAW

(b) Address CHARLESTON, Mo

17. (a) BURIAL (b) Date thereof 3-15-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OAK GROVE - CHARLESTON, Mo

18. (a) Signature of funeral director LAIR NUNNELER

(b) Address CHARLESTON, Mo

19. (a) 3-14-41 (b) 11  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 12<sup>TH</sup>  
year 1941 hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from 8-6-1940 to 3-9-1944

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

Immediate cause of death Hypertensive Heart Disease & Decompensation

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 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) \_\_\_\_\_  
(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)  
Means of injury \_\_\_\_\_

23. Signature W. J. Fungal (M. D. or other) 11  
Address 204 S. Locust St Date signed 3-13-44

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

RECEIVED

District Health Officer No.

District File Number 441-4

Date Filed 4/4/41

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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

*John P. Rummel Jr.*

Licensed Embalmer No. 3851

P. O. Address Charleston

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING: (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11407

Registration District No. 566

Primary Registration District No. 3030

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Mississippi  
(b) City or town Charleston  
(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 \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

In this community \_\_\_\_\_  
years, months or days  
3. (a) PRINT FULL NAME John Elijah Coleman  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Mar day 12  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_;

4. Sex m 5. Color or race col 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

8. AGE: Years 77 Months 0 Days 1  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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

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

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

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) June 7 1941 (b) F. Vernon  
(Date received local registrar) (Registrar's signature)

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 John F. Frangel (M. D. or other) \_\_\_\_\_

Address Charleston Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

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

2  
-41  
39  
26390

11407

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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 the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**