

7. S. No. 2
FORM-5-43
Rev. 5-17-39
I X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39027

FILED JAN 5 1946

State File No. 11232

Registration District No. 218

Primary Registration District No. 4003

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital - Max C. Starkloff
(If not in hospital or institution, write street number or location) Memorial

(d) Length of stay: In hospital or institution 11 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 72

(c) City or town GIDEION
(If outside city or town limits, write "RURAL")

(d) Street No. 1
(If rural, give location) N.R.

(e) Citizen of foreign country? - (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME ROBERT COLEMAN

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 1 1877
(Month) (Day) (Year)

8. AGE: Years 68 Months 8 Days 18 If less than one day
hr. _____ min. _____

9. Birthplace GIDEION, MO.
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

12. Name UNKNOWN

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

14. Maiden name UNKNOWN

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

16. (a) Informant ROBERT COLEMAN

(b) Address GIDEION, MO.

17. (a) REMOVAL (b) Date thereof 12-19-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation PIGGOTT, ARK.

18. (a) Signature of funeral director HOWARD F. ROWLAND

(b) Address 435 S. WASHINGTON AV.

19. (a) DEC 21 1945 (b) J. F. Breyer
(Date received local registrar's certificate) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 19th
year 1945 hour 5:35 minute A M.

21. I hereby certify that I attended the deceased from 12/8/45
19____, to 12/19/45, 19____;
that I last saw him alive on 12/19/45, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia

Due to _____

Due to _____

Other conditions 106
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of 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? _____
(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)

23. Signature Herbert C. Fritz (c) Means of injury _____
Date signed 12/19/45

Address _____ Date signed _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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JAN 10 1945

FEB 7 1943

11282

11282

FEB 4 1946

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.....

Ray Campbell

Licensed Embalmer No..... *3881*

P. O. Address..... *St. Louis Mo*

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, fact should be so stated above.