No. 2
-12-45
5-17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 6 1947

Registration District No. 128

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

30903

State File No.

Primary Registration District No. 2000

Registrar's No. 798

1. PLACE OF DEATH:

(a) County: Greene
(b) City or town: Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Burge Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community: 54 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Greene 39
(c) City or town: Springfield 2
(If outside city or town limits, write "RURAL")
(d) Street No.: 1818 E. Central 6 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Samuel P. Coley
3. (b) If veteran, name war: None
3. (c) Social Security No.: None
4. Sex: Male 0
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Mattie Coley
6. (c) Age of husband or wife if alive: 78 years
7. Birth date of deceased: April (Month) 25 (Day) 1868 (Year)

8. AGE: Years	Months	Days	If less than one day
81	4	14	hr. min.

9. Birthplace: ? (City, town, or county) Indiana (State or foreign country)
10. Usual occupation: Retired Iron Foundry Foreman
11. Industry or business: Iron Foundry

FATHER
12. Name: Samuel Coley
13. Birthplace: ? (City, town, or county) S. Carolina (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) ? (State or foreign country)

16. (a) Informant: Ray Coley
(b) Address: 1150 E. BrowerSpringfield Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/11/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Hazelwood Cemetery.
18. (a) Signature of funeral director: J. W. Klingner
(b) Address: Springfield Mo.
19. (a) 9-11-47 (Date received local registrar) (b) W. E. Handley MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September Day 9 year 1947 hour 10 minute 10 A. M.

21. I hereby certify that I attended the deceased from 9-3-, 1947 to 9-9-, 1947 that I last saw him alive on 9/8/, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Acute heart failure due to	
Chronic Myocardia	6 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): Cystitis + Senility	

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

23. Signature: C. E. Feller (M. D. or other)
Address: Springfield Mo Date signed: 9/9/47

(Licensed Embalmer's Statement on Reverse Side)

OCT 27 1948

OCT 27 1948

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 Max Rhodes

Licensed Embalmer No. 407

P. O. Address Springfield

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.