

No. 2
-1/47
5-17-39

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **36603**
Registrar's No. **2147**

National Office of Vital Statistics
FILED OCT 20 1947
Registration District No. **3745**

Primary Registration District No. **6076**

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

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **Lemay**
(c) Name of hospital or institution: **9101 So. Broadway**
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(d) Street No. **#16 Windermere Pl?**
(e) Citizen of foreign country? **No** (Yes or No) /
If yes, name country.....

3. (a) PRINT FULL NAME **CLARA E. COLEMAN.**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **no**

4. Sex **Female** 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 **1882** years
7. Birth date of deceased **April 4 1882**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 6 6 ..hr. ..min.

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business **School teacher**

12. Name **John R. Coleman**

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

14. Maiden name **Elizabeth Orendorff**

15. Birthplace **St. Charles Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Ed. M. Primeau**

(b) Address **#16 Windermere Pl.**

17. (a) **Burial** (b) Date thereof **10/13/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **C. R. Lupton & Sons**

(b) Address **7233 Delmar Blvd**

19. (a) **10-13-47** (b) **Cent. A. Schaffner**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **10**
year **1947** hour **7:15** minute **P.** M.

21. I hereby certify that I attended the deceased from **6-10-45**, 19....., to **10-10-47**, 19.....
that I last saw **her** alive on **10-9-47**, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death **Chc. Pulm Tub**
Due to.....
Due to..... **13**

Other conditions.....
(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?..... (Specify type of place)

While at work?..... Means of injury.....

23. Signature **William C. Kuska M.D.** (Physician or other).....

Address **6076 Grand Blvd** Date signed **10/17/47**

Duration
5 yrs

PHYSICIAN
Underline the cause of which death should be charged statistically.

Missouri Club
92-6148
1-3

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 Clarence K. Murray

Licensed Embalmer No. 4011

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.