

FILED AUG 9 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22121

BIRTH NO. _____		REG. DIST. NO. 42	PRIMARY REG. DIST. NO. 1000	Registrar's No. 839
1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission). a. STATE Missouri b. COUNTY Buchanan		
b. CITY OR TOWN St. Joseph	c. LENGTH OF STAY (in this place) 60 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		
d. FULL NAME OF HOSPITAL OR INSTITUTION Mitchell Nursing Home 404 So. 16th Street		d. STREET ADDRESS (If rural, give location) 404 So. 16th Street 01170		
3. NAME OF DECEASED (Type or Print) a. (First) Clotilda b. (Middle) Ray c. (Last) Coleman		4. DATE OF DEATH July 28 1954		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov. 18 - 1876	
9. AGE (in years last birthday) 77		10. USUAL OCCUPATION (If we kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Stewartville, Mo.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James A. Ray		
13b. MOTHER'S MAIDEN NAME Mariah		14. NAME OF HUSBAND OR WIFE William J. Coleman		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. Mary H. Bluff, 331 X
17. ADDRESS Route 6 - Box 354, St. Joseph, Mo.		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		MEDICAL CERTIFICATION		
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 week		
DUE TO (c) Semility and general debility		Ukn.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Ukn.		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR
22. I hereby certify that I attended the deceased from 1/23/1951, to 7/28-1954, that I last saw the deceased alive on 7/28/1954, and that death occurred at 3:40 P. m., from the causes and on the date stated above.				
23a. SIGNATURE J. F. Mundy		23b. ADDRESS (Degree or title) M.D. 2801 Sacramento, St. Joseph, Mo.		23c. DATE SIGNED 7-30-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE July 30, 1954		24c. NAME OF CEMETERY OR CREMATORY Highland Cemetery
24d. LOCATION (City, town, or county) St. Joseph, Mo.		(State)		
DATE REC'D BY LOCAL REG. Aug 2, 1954		REGISTRAR'S SIGNATURE Esther M. Allison		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mrs. H. Alexander, St. Joseph, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

Wm H. Alexander

Licensed Embalmer No. 4450

P. O. Address St. Joseph, 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.