

FILED SEP 26 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31931

State File No.

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 30711 Registrar's No. 176

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Marshall</u>		c. CITY OR TOWN <u>Gilham</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>3 days</u>		e. STREET ADDRESS (If rural, give location) <u>3 miles North Gilham Mo</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Fitzgibbon Hospital</u>			

3. NAME OF DECEASED (Type or Print) <u>ROLAND SAMUEL COLEMAN</u>	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept-2-1955</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED-NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH (Month) (Day) (Year) <u>January-20-1899</u>	9. AGE (In years) (Months) (Days) <u>55-7-12</u>	IF UNDER 1 YEAR (Hours) (Min.)	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Near Miami Saline Co Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	

13a. FATHER'S NAME <u>Wm Coleman</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Catherine Winters</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. (If yes, give war or status of service) <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Criddle Heard, Gilham Mo</u>	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Heart failure</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 8-30, 1955, to Sept 2, 1955, that I last saw the deceased alive on 9-2, 1955, and that death occurred at 2:05 P m., from the causes and on the date stated above.

23a. SIGNATURE <u>S.P. Simmons / Simmons</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Marshall, Mo.</u>	23c. DATE SIGNED <u>9-20-55</u>
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24a. BURIAL CREMATION REMOVAL (Specify)	24b. DATE <u>9-3-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Miami Cemetery, Miami, Mo</u>	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. <u>9-20-55</u>	REGISTRAR'S SIGNATURE <u>Cecil J. Read / Deputy</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Joe Jones, State, Mo</u>	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

300
48

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.....
Signature of Student Embalmer

Signed *James E. [Signature]*
.....
Licensed Embalmer No. *3*
P. O. Address *State*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.