

Health, Welfare, Public Service, 0300-1-56, All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

FILED DEC 3 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41180

STATE FILE NUMBER

Registration District No. 217 Primary Registration District No. 5785 Registrar's No. 84

1. PLACE OF DEATH a. COUNTY <b>Mississippi</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Miss.</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bertrand</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Bertrand</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Route 1</b>		Length of stay in 1b <b>6 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>Route 1, Box 28</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>Coleman</b> Last <b>Coleman</b>			4. DATE OF DEATH Month <b>November</b> Day <b>26</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>Married</b> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 1, 1898</b>	9. AGE (In years last birthday) <b>59</b> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Charleston, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Richard Coleman</b>			14. MOTHER'S MAIDEN NAME <b>Minerva Johnson</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Mrs. Roberta Coleman, Charleston, Mo.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Natural Causes</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ g. m. _____ p. m. _____ Month _____ Day _____ Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY _____ STATE _____
21. I attended the deceased from <b>After death as Coroner</b> and last saw <sup>her</sup> <sub>him</sub> alive on _____ Death occurred at <b>7:00 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Elmer Merylle Coroner</b>			22b. ADDRESS <b>Charleston, Mo.</b>		22c. DATE SIGNED <b>11/27/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Nov. 30, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Charleston, Mo.</b>	
24. FUNERAL DIRECTOR <b>L. P. Sparks</b>		ADDRESS <b>Charleston, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>11-29-57</b>	26. REGISTRAR'S SIGNATURE <b>Dorothy B. Hathorn</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

RECEIVED  
Miss. Co. Health D  
County File No. \_\_\_\_\_  
Date Filed 12-2-

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 Edward A. Ruffin

Licensed Embalmer No. 5022  
2501 Pop  
P. O. Address Cairo, IL

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.