

THE DIVISION OF HEALTH OF MISSOURI				STANDARD CERTIFICATE OF DEATH			
IC-6/687 050 R# 121045		Registration District No. <u>317</u>		Primary Registration District No. <u>500</u>		STATE FILE NUMBER <u>58-042802</u> Registrar's No. <u>2930</u>	
NOV 18 1958							
1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST LOUIS</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JEFFERSON BARRACKS</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>BALLWIN</b>		4000 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>VETERANS ADMINISTRATION HOSP. 99 DAYS</b>		Length of stay in lb		d. STREET (If outside, give location) ADDRESS <b>#7 NANCY PLACE</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LLOYD</b> Middle <b>EDWARD</b> Last <b>COLEMAN</b>			4. DATE OF DEATH Month <b>11</b> Day <b>12</b> Year <b>58</b>				
5. SEX <b>MALE</b> <input type="radio"/>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-20-18</b>	9. AGE (In years last birthday) <b>40</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STOREKEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AIRCRAFT</b>		11. BIRTHPLACE (City and state or country) <b>BLISS, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>THEODORE COLEMAN</b>		13b. MOTHER'S MAIDEN NAME <b>MAE GUENTHER</b>		14. NAME OF HUSBAND OR WIFE <b>ROSEMARY COLEMAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>YES WW-II</b>		16. SOCIAL SECURITY NO. <b>496116309</b>		17. INFORMANT Address <b>V.A. HOSPITAL RECORDS, JEFF BRKS, 25, 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>COARSE NODULAR CIRRHOSIS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12 YEARS</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>CHRONIC HEPATITIS</b>						<b>13 YEARS</b>	
DUE TO (c) <b>5810</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 Month, Day, Year a.m. p.m.							
20d. INJURY OCCURRED WHILE AT <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. <b>V.A.</b> attended the deceased from <b>8-5-58</b> to <b>11-12-58</b> Death occurred at <b>8:15 PM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>W. Oppler</i> (Degree or title) <input type="radio"/>			22b. ADDRESS		22c. DATE SIGNED		
<b>W. OPPLER, M.D., Director Professional Services, Vet Adm Hosp, J.B. 25, Mo.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>11-15-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>JEFF. BARRACKS, Mo</b>		
24. FUNERAL DIRECTOR <b>Schader Paul Home,</b>		ADDRESS <b>Ballwin Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>11-13-58</b>		26. REGISTRAR'S SIGNATURE <i>Robert R. Dombke M.D.</i>		

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 Richard M. Bopp

\_\_\_\_\_-Licensed Embalmer No. 4584  
P.O. Address Ballerwin, Me

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.