

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045517
STATE FILE NUMBER

JAN 12 1958

318

1003

12549

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

300
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 1125 N. Compton	
Length of stay in lb 40 yrs		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARSHALL Middle COLEMAN Last			4. DATE OF DEATH Month Dec. Day 24 Year 1958
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1900 Oct. 19, 1900*
9. AGE (In years last birthday) 58	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packing House Employee	11. BIRTHPLACE (City and state or country) Bolton, Miss.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Hamp Coleman		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 499-05-0976	17. INFORMANT Bertha Coleman Address 3220 Bell Ave.
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver DUE TO (b) Arterio Sclerosis DUE TO (c) 581.0 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 _____ 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. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 7:20 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Joseph M. Quinn</i> (Degree or title) 3		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 12/27/58		(State)	
23a. BURIAL, CREMATION, RECOVERY (Specify) Removal	23b. DATE Dec 30 1958	23c. NAME OF CEMETERY OR CREMATORY Greenwood	23d. LOCATION (City, town, or county) St. Louis, Co Mo
24. FUNERAL DIRECTOR J. H. RANDLE & SON ADDRESS 3133 Bell Ave.		25. DATE RECD. BY LOCAL REG. DEC 27 '58	26. REGISTRAR'S SIGNATURE <i>J. Earl Smith M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Catherine N. Harris*

Licensed Embalmer No. *4458*
P. O. Address *4181 Wash*

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.