

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED MAY 8 1959 Registration District No. 317 Primary Registration District No. 546 Registrar's No. 1259

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>FRANKLIN</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <u>OVERLAND</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>SULLIVAN</u> 0360		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2408 GOTHARD</u>			Length of stay in lb <u>6 MOS.</u>	d. STREET ADDRESS (If outside, give location) <u>R. R. 4 - Hi-WAY K</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>MAY</u> Last <u>COLDWELL</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 12, 1883</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>22</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>WOODBURN, ILL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>THEODORE FINLEY</u>			13b. MOTHER'S MAIDEN NAME <u>SARAH TAULBEE</u>		14. NAME OF HUSBAND OR WIFE <u>WILLIAM COLDWELL</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT Address <u>NEEL DEWEY OVERLAND, MO.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocarditis (chronic)</u>						INTERVAL BETWEEN ONSET AND DEATH	
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)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>	
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.) <u>4222</u>				
20c. TIME OF INJURY Hour <u></u> Month, Day, Year a.m. <u></u> p.m. <u></u>							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>SULLIVAN</u>		COUNTY <u>MO</u> STATE <u>MO</u>	
21. I attended the deceased from <u>March 1 - 59</u> to <u>May 4 - 59</u> and last saw her/him alive on <u>May 1 - 1959</u> Death occurred at <u>May 4 - 1959 - 6:45 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>E. C. Sterling M.D.</u> (Degree or title)				22b. ADDRESS <u>8105 Page St. Louis 30 Mo</u>		22c. DATE SIGNED <u>5-4-59</u>	
23a. HOSPITAL OR CREMATION (If removal specified) <u>REMOVED</u>		23b. DATE <u>MAY 7, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>REEDVILLE BAPTIST CH. CEM.</u>		23d. LOCATION (City, town, or country) (State) <u>SULLIVAN MO</u>		
24. FUNERAL DIRECTOR <u>Stevenson Sullivan, Mo.</u>			ADDRESS	25. DATE RECD. BY LOCAL REG. <u>5-6-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>		

 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION

 Health, Welfare and Public Service
 X
 300
 -57
 Doctor, coroner, etc., must use only standard form. 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 *Harrison M. Eaton*.....

Licensed Embalmer No. *4192*.....

P. O. Address.. *Sullivan, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.