

RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS SEP 1 1959

59-030317

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7718** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI Length of stay in 1b _____ c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY JEFFERSON c. CITY OR TOWN DE SOTO Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 200 E 3rd Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First BETTY Middle J. Last COLEMAN			4. DATE OF DEATH Month AUGUST Day 17 Year 1959				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH JAN 25, 1920	9. AGE (last birthday) 39	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (City and state or country) ANAPOLIS, MO		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME JAKE BOLDEN			13b. MOTHER'S MAIDEN NAME ADDIE SUTTON		14. NAME OF HUSBAND OR WIFE HILARY COLEMAN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 487-28-4815		17. INFORMANT Address PAUL COLEMAN DE SOTO, MO		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS, PRIMARY SITE SIGMOID COLON Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 153.3		INTERVAL BETWEEN ONSET AND DEATH 2 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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 _____ a.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 **APRIL 27, 1959** to **AUGUST 17, 1959** and last saw her/him alive on **AUGUST 17, 1959**
 Death occurred at **8:00 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>FR Bradley</i> M. D.		22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 8/18/59	
23a. BURIAL CREMATION, REMOVAL, (Specify) Burial		23b. DATE Aug 19, 1959		23c. NAME OF CEMETERY OR CREMATORY CITY	
24. FUNERAL DIRECTOR ADDRESS MAHN Funeral Home De Soto, Mo		25. DATE RECD. BY LOCAL REG. Aug 20 '59		26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>	

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Daniel J. Mahan

Licensed Embalmer No. 4326

P. O. Address Altoona, Pa.

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.