

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 17 1960

-60-032029

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7508** STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS | | | Length of stay in 1b | | c. CITY OR TOWN MISSOURI ST. LOUIS |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION HOMER PHILLIPS HOSP | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 3964th WESTMINSTER |
| 3. NAME OF DECEASED (Type or print) First Middle Last DONNELL L. COLEMAN | | | 4. DATE OF DEATH Month Day Year 7-25-60 | | |
| 5. SEX MALE | 6. COLOR OR RACE colored | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 6-9-60 | 9. AGE (last birthday) — | IF UNDER 1 YEAR Months Days Hours Min. 16 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) ST. LOUIS, MO | | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
| 13a. FATHER'S NAME DONNELL L. MATTHEW | | 13b. MOTHER'S MAIDEN NAME ESTELLA BROOKS | | 14. NAME OF HUSBAND OR WIFE | |

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | 16. SOCIAL SECURITY NO. — | 17. INFORMANT MRS ESTELLA COLEMAN, WESTMINSTER Address 3964th |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) INTERSTITIAL PNEUMONITIS | | |
| DUE TO (b) | | |
| DUE TO (c) 763.0 | | |

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| 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 type="checkbox"/> No <input type="checkbox"/> Unknown | |
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| 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 **7:25 P** and last saw **her** alive on _____

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| 22a. SIGNATURE Paul Simon (Degree or title) Coroner | 22b. ADDRESS 1300 Clark | 22c. DATE SIGNED 7/28/60 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE 7-28-60 | 23c. NAME OF CEMETERY OR CREMATORY GREENWOOD CEM. | 23d. LOCATION (City, town, or county) (State) ST. LOUIS CITY MO |
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| 24. FUNERAL DIRECTOR A.F. WALTON 2707 STODDARD ST | 25. DATE RECD. BY LOCAL REG. JUL 28 1960 | 26. REGISTRAR'S SIGNATURE Loard Smith, M.D. |
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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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.