

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035222

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2823

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> COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>	Length of stay in 1b <u>DOA</u>	c. CITY OR TOWN	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>COUNTY HOSP.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6908 FOXCROFT AVE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>L.</u> Last <u>COLEMAN</u>	4. DATE OF DEATH Month <u>OCT</u> Day <u>5</u> Year <u>1961</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/15/17</u>	9. AGE (last birthday) <u>44</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUDITOR</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>US AIR FORCE</u>	11. BIRTHPLACE (City and state or country) <u>COLUMBUS OHIO</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>JOHN L. COLEMAN</u>	13b. MOTHER'S MAIDEN NAME <u>ROSE (UNKNOWN)</u>	14. NAME OF HUSBAND OR WIFE <u>CATHERINE COLEMAN</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES 1941-1961</u>	17. INFORMANT <u>Catherine E. Coleman</u> Address <u>6908 FOXCROFT</u>
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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: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</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)	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 checked="" type="checkbox"/> NO <input 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.)
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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
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at 8:16 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Raymond Shaw</u> (Degree or title) <u>Coroner Clayton, Mo.</u>	22b. ADDRESS	22c. DATE SIGNED <u>10/10/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL 10/6/61</u>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOSEPH</u>	23d. LOCATION (City, town, or county) (State) <u>COLUMBUS, OHIO</u>
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24. FUNERAL DIRECTOR <u>WOLFERSBERGER-MEYER O'FALLON, ILL</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>10-6-61</u>	REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Frank Proff

Licensed Embalmer No. 4356

P. O. Address St. Louis, 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.