

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-024503

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6481

FILED JUL 6 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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		a. STATE Missouri b. COUNTY St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		c. CITY OR TOWN Olivette	
Length of stay in 1b 1 day		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS 2 Branford Drive		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Harold Middle Frederick Last Coleman		Month June Day 30 Year 1962	
5. SEX Male	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 5-17-1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purchasing Agent (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Rexall Drug Co.	9. AGE (last birthday) 67
11. BIRTHPLACE (City and state or country) Buffalo, N.Y.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Tom W. Coleman		13b. MOTHER'S MAIDEN NAME Kate Ann (Unknown)	
14. NAME OF HUSBAND OR WIFE Dorothy Coleman		17. INFORMANT Robert Coleman, 3108 45th St., Indianapolis, Ind.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.I		17. ADDRESS Indianapolis, Ind.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema			INTERVAL BETWEEN ONSET AND DEATH 1 hr
DUE TO (b) Myocardial failure.			1 day
DUE TO (c) Valvular heart dis. & R.B.B.B.			7-8 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes			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
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 421.4
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	
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 1957 to June 30 '62 and last saw him alive on June 29 '62 Death occurred at 10 AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i>		22b. ADDRESS 5427 Delmar Blvd	
22c. DATE SIGNED 7-1-62		22d. CITY, TOWN, OR COUNTY (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Air)		23b. DATE 7/1/62	
23c. NAME OF CEMETERY OR CREMATORY Milton Cemetery		23d. LOCATION (City, town, or county) (State) Milton, Massachusetts	
24. FUNERAL DIRECTOR Alexander & Sons, 6175 Delmar Blvd.		25. DATE RECD. BY LOCAL REG. JUL 1 1962	
26. REGISTERAR'S SIGNATURE <i>[Signature]</i>		26. REGISTERAR'S SIGNATURE M.D.	

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 W E McCulloch

Licensed Embalmer No. 9422

P. O. Address 617 58th Ave

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.