

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-029803**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. \_\_\_\_\_

**318** Primary Registration District No. **1003**

Registrar's No. \_\_\_\_\_

**7918**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED AUG 9 1963**

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY		a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>		Length of stay in 1b <b>95 days</b>	c. CITY OR TOWN <b>St. Louis, Missouri</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA Hospital, St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1906 Bellglade</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED First Middle Last			4. DATE OF DEATH Month Day Year
<b>McDANIEL COLEMAN</b>			<b>7-15-63</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7-18-21</b>
		9. AGE (last birthday) <b>41</b>	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) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	11. BIRTHPLACE (City and state or country) <b>Trenton, Tennessee</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Abraham Coleman</b>		13b. MOTHER'S MAIDEN NAME <b>Annie Mae McDaniel</b>	
14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 6-11-43 to 10-4-</b>		16. SOCIAL SECURITY NO. <b>441x</b>	
17. INFORMANT <b>Veterans Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE LEFT HEART FAILURE</b> )			INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <b>MALIGNANT HYPERTENSION</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)			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"/>	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. Attended the deceased from <b>3-11-63</b> to <b>7-15-63</b> and last saw <sup>HE</sup> him alive on <b>7-15-63</b>		Death occurred at <b>6:15 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>Howard N. Ward</i> (Degree or title) <b>HOWARD N. WARD</b>		22b. ADDRESS <b>VAH, St. Louis, Missouri</b>	22c. DATE SIGNED <b>7-17-63</b> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	23b. DATE <b>7-21-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetary</b>	23d. LOCATION (City, town, or county) <b>Gibson Co. Tenn</b> (State)
24. FUNERAL DIRECTOR ADDRESS <i>John Humboldt</i>		25. DATE RECD. BY LOCAL REG. <b>AUG 5 1963</b>	26. REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i>

VS 300 Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

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