

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-042532**  
STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 249

DO NOT WRITE ON THIS STUB

AMENDED

OCT 28 1963

1. PLACE OF DEATH a. COUNTY <u>SCOTT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SCOTT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SIKESTON</u>		c. CITY OR TOWN <u>SIKESTON</u>	
Length of stay in 1b <u>6 Mo</u>		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>232 WILLIAM ST</u>		d. STREET ADDRESS (If outside, give location) <u>232 WILLIAM ST</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA ELVIRA COLEMAN</u>			4. DATE OF DEATH Month Day Year <u>10-13-63</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-4-1913</u>	9. AGE (last birthday) <u>50</u>	IF UNDER 1 YEAR IF UNDER 24 HR. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>COLDWATER MO.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>					

13a. FATHER'S NAME <u>THOMAS JEFFERSON GREER</u>		13b. MOTHER'S MAIDEN NAME <u>MARY BESS</u>		14. NAME OF HUSBAND OR WIFE <u>WALTER WALLACE COLEMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Morgan Able - Sikeston Mo</u>	

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>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
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 checked="" 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 10-1-63 to 10-13-63 and last saw her <sup>alive</sup> on 10-13-63  
Death occurred at 7:45 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>L. M. Lewis M.D.</u>	22b. ADDRESS <u>Northaven, Mo.</u>	22c. DATE SIGNED <u>10-23-63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>10-14-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VAL HALLA</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis MO</u>
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24. FUNERAL DIRECTOR <u>Walter Funeral Home - Sikeston Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Oct 25 1963</u>	26. REGISTRAR'S SIGNATURE <u>Jeanette Waldman</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ  
 USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59	DATE AMENDED
11007	
21007	
3	
4 1	
5 2	
6	
7 0	
8 2	
9 331x	
10	
11	
12 90-6	
13 2-0	

NOV 22 1963

**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 Raymond S. Lewis

Licensed Embalmer No. 3467

P. O. Address Sekeston 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.