

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-049343**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12551**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED DEC 27 1963**

VS 300  
Rev. 4/59

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2 **2259**  
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4 **0**  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Mo.</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>			Length of stay in 1b <b>9 yr 47 days</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis Chronic</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>221 S. Broadway</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Coleman</b> Last <b>Coleman</b>				4. DATE OF DEATH Month <b>12</b> Day <b>5</b> Year <b>1963</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-30-82</b>	9. AGE (last birthday) <b>81</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <b>Ohio</b>		11. BIRTHPLACE (City and state or country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Charles</b>			13b. MOTHER'S MAIDEN NAME <b>Elizabeth</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)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>St. Louis Chronic Hospital</b> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>72 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>COMPENSATIVE HEART FAILURE</b>							<b>1-2 WEEKS</b>
DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>							<b>10 YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>DECUBITUS ULCERS - CONVULSIVE DISORDER 4200</b>					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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>10-19-54</b> to <b>12-5-63</b> and last saw her/him alive on <b>12-5-63</b> Death occurred at <b>4:45 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>John Keeney M.D.</b> (Degree or title)			22b. ADDRESS <b>5800 Central Av</b>			22c. DATE SIGNED <b>12-7-63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>12-31-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>		23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b> (State)		
24. FUNERAL DIRECTOR <b>MO. ANATOMICAL BOARD, 1402 S. GRAND</b> ADDRESS			25. DATE RECD. BY LOCAL REG. <b>DEC 19 1963</b>		26. REGISTRAR'S SIGNATURE <b>Road Smith, M.D.</b>		

**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 \_\_\_\_\_

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.