

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

35989
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1. PLACE OF DEATH

County Schuyler Registration District No. 201
Township Prarie Primary Registration District No. 1211
City Queenscity Mo (No.) St. Ward)

2. FULL NAME E. S. COONS

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs Ida Coons

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 29 1861

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
68 3 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Michel Coons

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Pauline Coons

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

14. INFORMANT Mrs Ava McElhiney

(Address) Queenscity Mo

15. FILE NO. 19-24 REGISTRAR J. D. J. J. J.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 24 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 16 1929 to Oct 24 1929
that I last saw him alive on Oct 23 1929, and that death occurred, on the date stated above, at 10:20 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Necrosis of bone of foot
infection of tendency to
other foot.
155B (duration) 16 yrs. mos. ds.
CONTRIBUTORY Heart failure
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED (IF NOT AT PLACE OF DEATH) Home

19. DID AN OPERATION PRECEDE DEATH? no DATE OF

20. WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? injury of dead bone & X-ray (Signed) D. W. O. E. M. D.

. 19 (Address) Queenscity Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Queenscity Cemetery DATE OF BURIAL Oct 26 1929

20. UMBERTAKER Wm H West ADDRESS Queenscity Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1929

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