

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

Do not use this space.

1. PLACE OF DEATH

34

County Douglas

Township Boone

City

(No.

Registration District No. 272

Primary Registration District No. 5384

File No.

39082

Registered No.

St.

Ward)

2. FULL NAME

Daniel Coon

(a) Residence, No.

(Usual place of abode)

St.

Ward.

(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

W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

S.

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

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

Feb 7 - 1930

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

1

10

6

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

none

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Kansas

2

FATHER

13. NAME

Bert Coon

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Kansas

MOTHER

15. MAIDEN NAME

Arucilla Graham

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Kansas

17. INFORMANT (ADDRESS)

Bert Coon

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Whitewater Cemetery

DATE

Dec 14

1932

19. UNDERTAKER (ADDRESS)

Neighbors

20. FILED

Dec 14

1932

Boorman

Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

Dec. 13

1932

22. I HEREBY CERTIFY That I attended deceased from Nov 29, 1932, to Dec 13, 1932

I last saw him alive on Dec 12, 1932 Death is said

to have occurred on the date stated above, at 2 a m.

The principal cause of death and related causes of importance were as follows:

Bronchial Pneumonia

Date of onset Nov 28

Other contributory causes of importance:

Name of operation none Date of none

What test confirmed diagnosis clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed)

R M Norman

M. D.

(Address)

Arac Mo

JAN 23 1933

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.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Douglas
Township Boone
City Daniel Coon (No.)

Registration District No. 272
Primary Registration District No. 3384

File No.
Registered No. St. Ward

2. FULL NAME

(a) Residence, No. St. Ward
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>S</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u> </u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)		
7. AGE	YEARS	MONTHS
		DAYS
		If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
FATHER	13. NAME	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	
MOTHER	15. MAIDEN NAME	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	
17. INFORMANT (ADDRESS)		
18. BURIAL, CREMATION, OR REMOVAL PLACE DATE		
19. UNDERTAKER (ADDRESS)		
20. FILED <u>3/1</u> 19. <u>33</u> <u>EBBannon</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 13, 1932

22. I HEREBY CERTIFY, That I attended deceased from to , 19

I last saw h. alive on , 19 . Death is said to have occurred on the stated above, at m.

The principal cause of death and related causes of importance were as follows:

Broncho pneumonia Date of onset

Whooping Cough

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) , M. D.
(Address)

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

S-37082