

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

32457
Do not use this space.

1. ~~PERSONAL AND STATISTICAL PARTICULARS~~ **Brundy** 2 Registration District No. **327**
 (a) County **Brundy** 2
 (b) Township **Myers** 1 Primary Registration District No. **5457**
 (c) City ~~Brundy~~ (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds. _____
 2. PRINT FULL NAME **500 Mrs Nancy Ruhana Koon**
 (a) Residence, No. _____ St. (If nonresident, give city or town and State) _____
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **wid.**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Elias B Koon**
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **NOV 23 1848**
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. **90 9- 25**
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Retired**
 9. Industry or business in which work was done, as saw mill, bank, etc. **Widow's wife**
 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) **W. Va.** 1
 FATHER 13. NAME **Jesse Parish** 1
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **W. Va.** 1
 MOTHER 15. MAIDEN NAME **Catharine Price**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **U.S.A.**
 17. INFORMANT **McDeral Anderson**
 (ADDRESS) **Galt Mo R7A**
 18. BURIAL, CREMATION, OR REMOVAL PLACE **Berry Cem. near top** DATE **Sept 18 1939**
 19. FUNERAL DIRECTOR (NAME) **W. C. Weston**
 (ADDRESS) **Galt Mo**
 20. FILED **9-18-39** **W. C. Weston**
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Sept 17 1939**
 22. I HEREBY CERTIFY, That I attended deceased from **1-1-39**, to **8-17-39**
 I last saw her alive on **8-15-39** Death is said to have occurred on the date stated above, at **7:30 P.M.**
 The principal cause of death and related causes of importance were as follows:
Chronic Myocarditis Date of onset **?**
Arterio Sclerosis ?
 Other contributory causes of importance: _____
 Name of operation _____ Date of _____
 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) **W. C. Weston**, M. D.
 (Address) **Galt, 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.

RECEIVED

Death Certificate

District File Number

1039-1286

Date Filed

OCT 18 1939

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

Registered Apprentice No....., working under my personal supervision.

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 this body is not embalmed, above space should be left blank.