

36187  
5

DIVISION OF PUBLIC STATISTICS  
**CERTIFICATE OF DEATH** No.                     

1. PLACE OF DEATH  
 County Harrison State:                      Registered No. 5  
 Township Lincoln 1 or Village                      or  
 City                      No.                      St.                      Ward                       
 (If death occurred in a hospital or institution give its name instead of street and number)

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.

2. FULL NAME (PRINT) Chas Coulson 125  
 (a) RESIDENCE County                      City                       
 (Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH	
Decedent	3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. Single, Married, Widowed or Divorced (write the word). <u>Married</u>	21. DATE OF DEATH <u>Oct 21 1939</u>	
Father	5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>Mrs. Coulson</u>			22. I hereby certify that I attended deceased from <u>Oct 15-1939</u> to <u>Oct 21 1939</u>	
Mother	6. DATE OF BIRTH (month, day, and year) <u>May 6-1875</u>			I last saw <u>him</u> alive on <u>Oct 21 1939</u> . death is said to have occurred on the date stated above, at <u>2 2</u> m.	
Date of Death Day Year	7. AGE Years <u>64</u>	Months <u>5</u>	Days <u>15</u>	The principal cause of death and related causes of importance in order of onset were as follows: <u>Coronary Sclerosis</u> Date of onset <u>1937</u> <u>Coronary Thrombus</u> <u>10/21/39</u>	
Primary Cause	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Farmer</u>			Contributory causes of importance not related to principal cause: <u>                    </u>	
Duration of Illness Mos. Days	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>                    </u>			Name of operation <u>                    </u> Date of <u>                    </u>	
Secondary Cause	10. Date deceased last worked at this occupation (month and year) <u>                    </u>			What test confirmed diagnosis? <u>                    </u> Was there an autopsy? <u>no</u>	
Tertiary Cause	11. Total time (years) spent in this occupation <u>                    </u>			23. If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? <u>                    </u> Date of injury <u>                    </u> 19 <u>                    </u>	
Operation	12. BIRTHPLACE (city or town, State or country) <u>Missouri</u>			Where did injury occur? <u>                    </u> (Specify city or town, county, and State)	
Autopsy	13. BIRTHPLACE (city or town, State or country) <u>                    </u>			Specify whether injury occurred in industry, in home, or in public place	
Accident Mo. Year	14. NAME <u>Mat Brown</u>			Manner of injury <u>                    </u>	
Place of Accident	15. BIRTHPLACE (city or town, State or country) <u>Not known</u>			Nature of injury <u>                    </u>	
Manner of Injury	16. MAIDEN NAME <u>Loretta Jane Full</u>			24. Was disease or injury in any way related to occupation of deceased? <u>no</u> If so, specify <u>                    </u>	
Nature of Injury	17. BIRTHPLACE (city or town, State or country) <u>Not known</u>			(Signed) <u>O. J. Fullerton</u> M. D. <u>                    </u> (Address) <u>                    </u>	
Related to Occupation	18. INFORMANT <u>Mrs. Vera Coulson</u> <u>Blatfield MO</u>			Manner of injury <u>                    </u>	
Disposition	19. BURIAL, CREMATION, OR REMOVAL <u>Burial</u> Date <u>10-22 1939</u>			Nature of injury <u>                    </u>	
Attendant	20. LICENSED EMBALMER <u>                    </u> No. <u>2479</u> <u>                    </u> (Address) <u>                    </u>			24. Was disease or injury in any way related to occupation of deceased? <u>no</u> If so, specify <u>                    </u>	
	20. FILED <u>Oct 21 1939</u> <u>Chas Adair</u> 310 Registrar.				

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIANS

RECEIVED

District Health Officer No. 11;

District File Number 1139-1518

Date Filed NOV 14 1939

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY LICENSED EMBALMERS

Has decedent ever served in military or naval service of the U. S. If so, give name of War.....

I, H. C. Rhoads Licensed Embalmer No. 2479 hereby certify that

the body recorded on the reverse side of this certificate was embalmed by..... L. E.

No..... or by..... Registered student No.....  
working under my personal supervision.

Signed H. C. Rhoads

Licensed Embalmer No. 2479

NOTE: The above statement MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HAND WRITING.  
(Failure to comply with the above constitutes grounds for revocation of license).