

Registration District No. **174**

Primary Registration District No. **3035**

1. PLACE OF DEATH
(a) County **Lafayette**
(b) City or town **Livingston**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1 E. Main St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **Life** _____ (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO** (b) County **Lafayette**
(c) City or town **Livingston, MO**
(If outside city or town limits, write "RURAL")
(d) Street No. **E. Main St.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Leonard Coen**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **ma** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Sept 13 1870**
(Month) (Day) (Year)

8. AGE: Years **72** Months **3** Days **18** If less than one day hr. _____ min. _____

9. Birthplace **Livingston MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **farmer**

11. Industry or business _____

MOTHER FATHER
12. Name **John P. Coen**
13. Birthplace **Germany** 4
(City, town, or county) (State or foreign country)
14. Maiden name **Margaret Klapp**
15. Birthplace **Germany** 4
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss Elig Coen**
(b) Address **Livingston, MO**

17. (a) **Burial** (b) Date thereof **Jan 3-1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Livingston, MO**

18. (a) Signature of funeral director **Winkler**
(b) Address **Livingston, MO**

19. (a) **Feb-2-43** (b) **Mrs. Fred Schwalb**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan** day **1** year **1943** hour **9** minute **50 A.M.**

21. I hereby certify that I attended the deceased from **Nov 26-1942** to **Jan 1, 1943**
that I last saw him alive on **Jan 1, 1943** and that death occurred on the date and hour stated above.

Immediate cause of death **Acute myocardial Degeneration - with Hypostatic pneumonia** Duration **36 hrs.**
Due to **Stroka Paralytica** **4 days**
Due to **Central Hemorrhage** **35 days**
Other conditions **St. Liff and Hypertension**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations: _____
Of autopsy: _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (a) Means of injury _____
23. Signature **Dr. J. B. ...** (b) _____ (City or town) (State)
Address **Livingston, MO** Date signed **1/2/43**

115-8

CASE OR CONTAINER BEING RECORDED - MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 8,
District File Number 27
Date Filed 2-5-43

SEP 25 1944

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

Garret J. Tempel

Licensed Embalmer No.

3575

P. O. Address

Lexington, Va

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2680

Registration District No. 174

Primary Registration District No. 3035

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Lexington
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Leland Coen

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased Sept 13 1913
(Month) (Day) (Year)

8. AGE: Years 72 Months 3 Days _____ If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) Mo.

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day _____ year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I first saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death acute myocardial degeneration

Due to hypostatic pneumonia
bacterial pneumonia

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Dr. J. L. Bellman, Jr. (Date signed) _____

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

MOTHER FATHER

