. No. 2
1-4-41
5-17-39
X26390

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

FILED FEB 10 1943
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 10 1943

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6456

Registration District No. 137 Primary Registration District No. 5513 Registrar's No. 9

1. PLACE OF DEATH:

(a) County Henry

(b) City or town "Rural" Leesville Twp.
(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 years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED: 42 3 0

(a) State Missouri (b) County Henry

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

(d) Street No. near Tighwad
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME William Edward Coones

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Eva Coones

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Nov. (Month) 10 (Day) 1869 (Year)

8. AGE: Years	Months	Days	If less than one day
73	1	27	hr. min.

9. Birthplace Benton County (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Joseph B. Coones
13. Birthplace Alabama (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Clarice Wingate
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Grace Austin
(b) Address R.F.D. #2 Clinton, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 10, 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Cedar Grove Cemetery

18. (a) Signature of funeral director White-Reser
(b) Address Wersaw, Mo.

19. (a) Jan. 9 1943 (Date received by registrar) (b) Georgia Kitchen (Registrar's signature) G.K.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 7
year 1943 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from Dec 1, 1942, to Jan 7 1943; that I last saw him alive on 1-6-43 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypostatic pneumonia	3 days
Myocarditis	
Senility	
Due to	
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? (Specify type of place)
While at work (e) Means of injury

23. Signature Joseph B Coones (M. D. or other) M.D.
Address Clinton, Mo. Date signed 1-9-43.

(Licensed Embalmer's Statement on Reverse Side)

10 5 7

RECEIVED
District Health Officer No. 7
District File Number 1-43-16
Date Filed 2-8-43

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. 3053

P. O. Address Warsaw, Missouri.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 645-6

Registration District No. ____ Primary Registration District No. 5-513 Registrar's No. ____

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

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Rural
(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 years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Henry
(c) City or town Rural
(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 ____

3. (a) PRINT FULL NAME William E Cramer
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 M
6. (b) Name of husband or wife Eva
6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased Nov 10 (Month) — 1869 (Day) (Year)

8. AGE: Years 73 Months 1 Days 17 If less than one day ____ hr. ____ min.

9. Birthplace ____ (City, town, or county) ____ (State or foreign country)
10. Usual occupation ____
11. Industry or business ____
MOTHER FATHER
12. Name ____
13. Birthplace ____ (City, town, or county) ____ (State or foreign country)
MOTHER
14. Maiden name ____
15. Birthplace ____ (City, town, or county) ____ (State or foreign country)
16. (a) Informant ____
(b) Address ____
17. (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)
(c) Place: burial or cremation ____
18. (a) Signature of funeral director ____
(b) Address ____
19. (a) ____ (Date received local registrar) (b) ____ (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January Day 7
year 1943 hour ____ minute ____ M.
21. I hereby certify that I attended the deceased from ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypostatic Pneumonia	
Due to Hypocandritis	
Due to Hepatitis (Lobar)	
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature ____ (M. D. or other) ____
Address ____ Date signed ____