S. No. 2
1—5-42
5-17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 15 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Walker

State File No. 6457

Registration District No.

Primary Registration District No. 3023

Registrar's No. 22

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Clinton Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Biggs Nursing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 da
In this community 14 da (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Henry
(c) City or town Leeton Mo Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Rural South West
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Sarah Bell Coulson

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

4. Sex Fe
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Wm Belden Coulson
6. (c) Age of husband or wife if alive 80 years
7. Birth date of deceased 10 (Month) 8 (Day) - 1867 (Year)

8. AGE: Years	Months	Days	If less than one day
75	2	16	hr. min.

9. Birthplace Davis Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Bo Adkinson
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 W. B. Coulson
(b) Address Leeton Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-43 (Month) (Day) (Year)
(c) Place: burial or cremation Shawnee Mound
18. (a) Signature of funeral director Fred Wilkinson
(b) Address Clinton Mo
19. (a) January 26 1943. (Date received local registrar) Georgia Kitchen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 24 year 1943 hour 4 minute 45 PM
21. I hereby certify that I attended the deceased from 1-10, 1943, to 1-24, 1943; that I last saw her alive on 1-10, 1943, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death septic ... fracture of hip and femur	14 da
Due to fall at home	3 mo
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) 042
(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 H. S. Walker (M.D. or other) M.D.
Address Clinton Mo Date signed 1-25-43

1664
(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 1-43-128
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
E L WILKINSON, Registered Apprentice No. 341
working under my personal supervision.

Signed Fred Wilkinson
Licensed Embalmer No. 2478
P. O. Address Clinton Ark

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.

V. S. No. 2B
0M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6457

Registration District No. ______ Primary Registration District No. 3023 Registrar's No. ______

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

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Clinton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Biggs Nurs Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 da
In this community 14 da (Specify whether years, months or days)

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 Sarah B Coulson
3. (b) If veteran, name war ______
3. (c) Social Security No. ______
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife ______
6. (c) Age of husband or wife if alive 80 years
7. Birth date of deceased Oct 8 - 1867 (Month) (Day) (Year)
8. AGE: Years 75 Months 3 Days ______ If less than one day ______ hr. ______ min.
9. Birthplace ______ (City, town, or county) ______ (State or foreign country)
10. Usual occupation ______
11. Industry or business ______
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 27 year 1943 hour ______ minute ______ M.
21. I hereby certify that I attended the deceased from ______, 19___, to ______, 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 Septic poisoning from old sore	
Due to Fall at home	
Due to ______	
Other conditions (Include pregnancy within 3 months of death) 1867 18	
Major findings: Of operations ______	PHYSICIAN Underline the cause to which death should be charged statistically.
Of autopsy ______	

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident fall at home
(b) Date of occurrence Dec 20, 1942
(c) Where did injury occur? home (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? home on Farm (Specify type of place)
While at work? yes (e) Means of injury Fracture hip
23. Signature H Walker (M. D. or other) M.D
Address Clinton Mo Date signed 3-30-43