

Registration District No.

Primary Registration District No.

Registrar's No.

FILED MAY 1943 41

3025

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

1. PLACE OF DEATH:

(a) County: Howell  
(b) City or town: West Plains, mo  
(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: Kelso H. Koons

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

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

6. (b) Name of husband or wife: Mrs Koons 6. (c) Age of husband or wife if alive: \_\_\_\_\_ years

7. Birth date of deceased: Nov 15-1866  
(Month) (Day) (Year)

8. AGE: Years: 77 Months: 7 Days: 20 If less than one day: \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation: Farmer

11. Industry or business:

MOTHER FATHER { 12. Name: Henry Koons  
13. Birthplace: Missouri  
14. Maiden name: Miss Hardwick  
15. Birthplace: Missouri

16. (a) Informant: LeGrand Koons

(b) Address: West Plains, mo

17. (a) (Burial, cremation, or removal): Home (b) Date thereof: 3-26-43  
(Month) (Day) (Year)

(c) Place: burial or cremation: Home

18. (a) Signature of funeral director: Phibbons

(b) Address: West Plains, mo

19. (a) 4-6-43 (b) Phil Koons  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: mo (b) County: Howell  
(c) City or town: West Plains  
(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: 3 day: 25 year: 1943 hour: 3 minute: 40 M.

21. I hereby certify that I attended the deceased from 3-19-1943 to 3-25-1943; that I last saw him alive on 3-24-1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic arteriosclerosis; myocarditis; hypertension

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions: Cerebral arteriosclerosis; Angina  
(Include pregnancy within 3 months of death)

Major findings: Of operations: 93d  
Of autopsy: \_\_\_\_\_

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) (c) Means of injury: \_\_\_\_\_

23. Signature: Edel Schen (M. D. or other) MD  
Address: West Plains, mo Date signed: 4-2-43

RECEIVED

District Health Officer No. 6

District File Number 573279

Date Filed 5-3-43

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 Roger D Roberts

Licensed Embalmer No. 3422

P. O. Address West Plains, Mo

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.