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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

22579

State File No.

ED JUL 14 1943

Registration District No. 338

Primary Registration District No. 4501

Registrar's No.

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

1. PLACE OF DEATH:
(a) County Stodard
(b) City or town Bloomfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bloomfield Mo., 3 Jail
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Stodard 103 2 0
(c) City or town Bloomfield
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Sam Coy
3. (b) If veteran, name war first World war
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced 9
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 2 (Day) 1897 (Year)

8. AGE: Years 46 Months 6 Days 1 If less than one day hr. min.

9. Birthplace Pontiac (City, town, or county) ark (State or foreign country)
10. Usual occupation Tavern owner
11. Industry or business
FATHER
12. Name Sam Coy
13. Birthplace Kissemills Mo (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Mary Burchett
15. Birthplace Kirkwood Mo (City, town, or county) (State or foreign country)
16. (a) Informant Geo Coy
(b) Address St Louis Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-43 (Month) (Day) (Year)
(c) Place: burial or cremation Woodlawn
18. (a) Signature of funeral director Frank Cotrell
(b) Address Poplar Bluff Mo
19. (a) July 6th 1943 (Date received local registrar) (b) Pearl Elmore (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3 year 1943 hour 7 30 minute 30 P. M.
21. I hereby certify that I attended the deceased from June 27, 1943, to July 3, 1943 that I last saw him alive on July 3, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Poison Bichloride of Mercury

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 163d

Major findings:
Of operations
Of autopsy

Duration

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) Suicide
(b) Date of occurrence June 27, 1943 Sa. M.
(c) Where did injury occur? Bloomfield Stodard Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Place (Specify type of place)
While at work? No (b) Means of injury Poison
23. Signature [illegible] (M. D. or other)
Address Bloomfield Mo Date signed 7/7/43

(Licensed Embalmer's Statement on Reverse Side)

JUL 16 1943

RECEIVED
District Health Office No. 2,
District File Number 243-855
Date Filed 7-13-43

N.C.C.

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 Grover W. Green

Licensed Embalmer No. 2964

P. O. Address Poplar Bluff M

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

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

No. 2B
1—5-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. FILED SEP 13 194

Registration District No. 338 Primary Registration District No. Registrar's No.

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Bloomfield
(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 (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

3. (a) PRINT FULL NAME Sam Coy
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male
5. Color or race W
6. (a) Single, widowed, married, divorced unk.
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan 2 1868 (Month) (Day) (Year)

8. AGE: Years 46 Months 6 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 July 3 year 1943 hour 3 minute 30 P.M.
21. I hereby certify that I attended the deceased from July 3, 1943; that I last saw him alive on July 3, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-22579