

No. 2  
1-542  
5-17-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29650

SEP 2 1943 374  
Registration District No.

Primary Registration District No. 6276

Registrar's No.

1. PLACE OF DEATH:

(a) County Worth

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

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

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

In this community 30 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Worth

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

(d) Street No. Sheridan, Mo.  
(If rural, give location)

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

3. (a) PRINT FULL NAME Augustus Clemons Coy

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 Della Coy 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased April 8 1872  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

71 3 13 hr. min.

9. Birthplace Taylor Co Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business \_\_\_\_\_

12. Name Jonathan Coy

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

14. Maiden name Mary Woods

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

16. (a) Informant Della Coy

(b) Address Sheridan Mo.

17. (a) burial (b) Date thereof 7-23-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sheridan Cemetery

18. (a) Signature of funeral director Arch C. Dunfee

(b) Address Front City, Mo.

19. (a) Aug 8 -43 (b) Arlene Scadden  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21  
year 1943 hour 11 minute 40 A.M.

21. I hereby certify that I attended the deceased from July 21 1943 to July 21 1943  
that I last saw him alive on July 20 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death 2. febrile (septic) followed with convuls ✓

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 131P ✓

Of operations \_\_\_\_\_

Of autopsy none

Duration

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 [Signature] \_\_\_\_\_

Address [Address] \_\_\_\_\_ Date signed 7-22-43

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

MOTHER, FATHER

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**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..... *Arch C. Duffer*.....  
Licensed Embalmer No. *3752*.....  
P. O. Address. *Grant City, 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.**