S. No. 2
M—2-43
5-17-39
I X35697

42
1
2

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 10 1944

Registration District No. 3 7

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3002

Primary Registration District No. 3023

Registrar's No. 22

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

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: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 50 years
years, months or days)

2. **USUAL RESIDENCE OF DECEASED:** 42
(a) State Mo (b) County Henry 1
(c) City or town Clinton Mo 9
(If outside city or town limits, write "RURAL")
(d) Street No. 316 N 7th St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Thomas L Cooner

3. (b) If veteran, name war World war #1

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced 3 Div

6. (b) Name of husband or wife Alice

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

7. Birth date of deceased July (Month) 23 (Day) 1873 (Year)

8. AGE: Years 71 Months 6 Days 1 If less than one day hr. min.

9. Birthplace Benton Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business

MOTHER FATHER
12. Name J. B. Cooner
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 Clyde Cooner
(b) Address Clinton Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-44 (Month) (Day) (Year)
(c) Place: burial or cremation National cem

18. (a) Signature of funeral director Consalus & Peery
(b) Address Clinton Mo

19. (a) January 25 1944 (Date received local registrar) Georgia Kitchen (Registrar's signature)

1064

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 24
year 1944 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 Probably Cancer Cause of Heart Disease	1
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN

Major findings:
Of operations
Of autopsy

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 H. Duvall M.D. (M. D. or other) MD
Address Clinton Mo Date signed 1-26-44
(acting Coroner)

Dr... Health Center No. 7
District File Number 1-44-130
Date Filed 2-9-44

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. 1951,

working under my personal supervision.

Signed J E Gonsalves

Licensed Embalmer No. 1891

P. O. Address Clayton 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.

S. No. 2B
0M—5-43
I X36930

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. _____

Registration District No. 127 Primary Registration District No. 3023 Registrar's No. 22

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: _____
(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 Thomas L. Coones
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 W
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 28 (Month) (Day) 1873 (Year)

8. AGE: Years 71 Months _____ Days _____ If less than one day: hr. _____ min.

9. Birthplace _____ (City, town, or county) Mo. (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)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January 24 day
year 1944 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 dont Know This man was found dead in bed. I want to have Justice Coones who was acting Coroner. in absence of	
Due to Coroner.	
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 L. L. Walker (M. D. or other) MD
Address _____ Date signed _____

3002