

S. No. 2
4-8-43
5-17-39
-1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1565

FILED FEB 13 1945

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Stickler Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days
(Specify whether
In this community 0
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Schuyler 98
(c) City or town Queen City rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Romona Louise Coons

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

4. Sex female 5. Color or race White 6. (a) Single, widowed, married, 0 divorced

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

7. Birth date of deceased August 26 1939
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>7</u>	<u>4</u>	<u>14</u>	hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name Mikel Dewey Coons

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

14. Maiden name Myrtle Gladys Coons

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

16. (a) Informant Myrtle G. Roulund

(b) Address Queen City Mo.

17. (a) burial (b) Date thereof Jan. 11, '45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Home C.

18. (a) Signature of funeral director Wm N. West

(b) Address Queen City Mo

19. (a) 1-11-45 (b) Dr. D. Wayne
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10
year 1945 hour 4 minute 45 a.m.

21. I hereby certify that I attended the deceased from Jan 3
1945 to Jan 10 1945
that I last saw her alive on Jan 9 1945
and that death occurred on the date and hour stated above.

Immediate cause of death
encephalitis
Due to Influenza
Due to _____

Other conditions Purpura Hemorrhagica
(Include pregnancy within 8 months of death)

Major findings:
Of operations _____
Of autopsy 338

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 0

23. Signature Stickler (M. D. or other) MD
Address Kirksville Mo Date signed 1-10-45

Duration
10 days
30 days
15 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

1049

Health Officer No. 10
District File Number 2-45-229
Date Filed FEB 11 1945

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 William H West

Licensed Embalmer No. 2882

P. O. Address Greenville 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.