

Registration District No. 156

Primary Registration District No. 2001

19
2
5
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Jasper
 (b) City or town Joplin
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Johns
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 weeks
23 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Caroline Coin
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
 4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Div.
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Aug. 31 1920
 (Month) (Day) (Year)

8. AGE: Years 24 Months 5 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace Carterville, Mo.
Factory worker (State or foreign country) 0

10. Usual occupation _____
 11. Industry or business _____

MOTHER, FATHER
 { 12. Name Bert Coin
 13. Birthplace Unknown 9
 14. Maiden name Nellie Williams (State or foreign country)
 15. Birthplace Joplin, Mo. 0
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Nellie McLaughlin
 (b) Address Joplin, Mo.
 17. (a) burial (b) Date thereof 2-6-45
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Osborne Memorial
Brownhill-Dillon

18. (a) Signature of funeral director Joplin, mo.
 (b) Address _____
 19. (a) 2-4-45 (b) J. H. ...
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jasper 49
 (c) City or town Joplin
 (If outside city or town limits, write "RURAL") 0
 (d) Street No. Rural (If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb 3 day 1945
 year 1945 minute 35 pm
 21. I hereby certify that I attended the deceased from Jan 1944
 _____, 19 _____ to Feb 3, 19 45
 that I last saw h. alive on Feb 3, 19 45
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Embolism in
rt. axilla
 Due to Embolism from
rt. deep veins
 Due to Pulmonary embolism
also present
 Other conditions _____ (Include pregnancy within 3 months of death)
pregnancy
 Major findings: _____ **PHYSICIAN**
 Of operations _____ Underline the cause to which death is attributed
 Of autopsy small infarct in rt. kidney & spleen **EDUCATIONAL CHARGES**

22. If death was due to external causes, fill in the following: **INFORMATION REQUESTED**
 (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)
 (b) Means of injury _____
 23. Signature J. H. ... (M. D. or other) J. H. ...
 Address Joplin Mo. Date signed Feb 4 1945

45-2-129

STATEMENT TO BE FILED IN THE STATE DEPT. OF HEALTH
STATE OF MISSOURI

STATE DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH

FORM 10
1-1-50

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

working under my personal supervision.

Signed

Carl A. Parrhill

Licensed Embalmer No.

3590

P. O. Address

Superior, 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.

STATE DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH