. No. 2
I—5-43
5-17-39
I X36671

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

FILED AUG 21 1945

State File No. 27891

Registration District No. 209 | Primary Registration District No. 3043 | Registrar's No. 179

1. PLACE OF DEATH:
(a) County: Marion
(b) City or town: Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Elizabeth Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 7 weeks (Specify whether years, months or days)
In this community: 25 years

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

3. (a) PRINT FULL NAME: Sarah. M. Coons
3. (b) If veteran, name war: No.
3. (c) Social Security No.: No.
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Sidney Coons
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: November (Month) 6 (Day) 1972 (Year)
8. AGE: Years 72 | Months 7 | Days 17 | If less than one day: hr. min.
9. Birthplace: Audrian Co. (City, town, or county) Missouri (State or foreign country)
10. Usual occupation:
11. Industry or business: At Home
FATHER 12. Name: John Mourning
FATHER 13. Birthplace: No record (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: No record
MOTHER 15. Birthplace: No record (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs Nola Fox
(b) Address: Palmyra, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6/25/45 (Month) (Day) (Year)
(c) Place: burial or cremation: Greenwood Cemetery
18. (a) Signature of funeral director: Lucas Lewis
(b) Address: Palmyra, Mo.
19. (a) 6-26-45 (Date received local registrar) (b) Dr. E. M. Lucke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23 year 1945 hour 6 minute A. M.
21. I hereby certify that I attended the deceased from June 4, 1945, to June 23, 1945; that I last saw her alive on June 23, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Cherrycardiotes — Duration
Due to:
Due to:
Other conditions (Include pregnancy within 3 months of death): Cherrypitis
Major findings: Of operations: / Of autopsy: 13 1/2

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: 6/25/45

1394 (Licensed Embalmer's Statement on Reverse Side)

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 [signature]

Licensed Embalmer No. 2382

P. O. Address Solomon 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.