

FILED DEC 28 1945

State File No. _____

Registration District No. 27

Primary Registration District No. 3017

Registrar's No. 141

1. PLACE OF DEATH:

(a) County Cooper
 (b) City or town Boonville
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Dr. Alex Ravensway Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 Weeks
(Specify whether)
 In this community 19 Years.
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cooper 27
 (c) City or town Boonville
(If outside city or town limits, write "RURAL")
 (d) Street No. 1314 Sixth St. 2
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No) 0
 If yes, name country _____

3. (a) PRINT FULL NAME Arthur Basil Cooter.

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 Mrs. Florence Cooter 6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased April 27 1900
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>45</u>	<u>7</u>	<u>10</u>	hr. _____ min. _____

9. Birthplace Kirkville Missouri. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Osteopathic Physician.

11. Industry or business _____

12. Name _____

13. Birthplace _____ 9
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. A. B. Cooter,
 (b) Address Boonville, Mo.

17. (a) Burial (b) Date thereof Dec. 9th/1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walnut Grove Cemetery

18. (a) Signature of funeral director Goodman H. Keller While at work _____ (e) Means of injury _____
 (b) Address Boonville, Mo.

19. (a) Dec. 8 - 1945 (b) Clay Morris
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 7
 year 1945 hour 9: minute 45 p.M.

21. I hereby certify that I attended the deceased from March, 1945, to Dec 7, 1945, that I last saw he alive on Dec 7, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal obstruction (small bowel obstruction) Duration 9 months

Due to Carcinoma of jejunum.

Other conditions _____ (Include pregnancy within 3 months of death) None

Major findings:
 Of operations Large irreparable Carcinoma of jejunum.
 Of autopsy None

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? _____

23. Signature Dr. Alex Ravensway (M. D. or other) _____
 Address Boonville, Missouri Date signed 12.10.45

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

MOTHER FATHER

1639

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health

District File Number

Date Filed

12-26-45

DEC 31 1945

DEC 29 1945

DEC 5 1946

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 George J. Poller
Licensed Embalmer No. 3062
P. O. Address Boonville, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 141

Registration District No. 82 Primary Registration District No. 3017

1. PLACE OF DEATH:

(a) County Casper
 (b) City or town Ballwin
 (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 _____)

In this community _____
 years, months or days)

3. (a) PRINT FULL NAME Arthur B. Coates
 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 m
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Apr 27 1920
 (Month) (Day) (Year)

8. AGE: Years 45 Months 7 Days 20 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) mo

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER }
 12. Name _____
 13. Birthplace _____ (City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
 (b) Address _____

17. (a) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
 year _____ hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ to _____, 19 _____;
 that I last saw him _____ alive on _____, 19 _____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Duration

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 _____ (M. D. or other) _____
 Address _____ Date signed _____

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

SUPPLEMENTARY

44

dt

JUL 15 1945

41005

DEC 5 1946