

Registration District No. **318**

Primary Registration District No. **1003**

**1. PLACE OF DEATH:**

(a) County \_\_\_\_\_  
(b) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: De PAUL HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 DAYS  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME FRANK COONS

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 SALLIE B. 6. (c) Age of husband or wife if alive 69 years  
7. Birth date of deceased JUNE 9 1878  
(Month) (Day) (Year)

8. AGE: Years 68 Months 9 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace BOONE Co MO  
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business FARMING

12. Name JOHN B. COONS  
13. Birthplace MO  
(City, town, or county) (State or foreign country)  
14. Maiden name LIZZIE RIDGEWAY  
15. Birthplace MO  
(City, town, or county) (State or foreign country)

16. (a) Informant MRS JOHN BALLEW  
(b) Address 7338 FORSYTHE BLD CLAYTON MO

17. (a) BURIAL (b) Date thereof 4-5-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Cem (COLUMBIA)

18. (a) Signature of funeral director ROWLAND MORTUARY SER.  
(b) Address 4355 WASHINGTON AV.

19. (a) APR 3 1947 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MISSOURI (b) County BOONE  
(c) City or town COLUMBIA  
(If outside city or town limit, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month MARCH day 31<sup>ST</sup>  
year 1947 hour 9 minute 00 M.

21. I hereby certify that I attended the deceased from 3-25-47  
19 \_\_\_\_\_ to Death 3-31 1947  
that I last saw him alive on 3/31/47  
and that death occurred on the date and hour stated above.

Immediate cause of death Money heart disease Duration 6 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)  
Enlarged prostate hypertrophy

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**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 death) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Joseph Deard (M. D. or other) \_\_\_\_\_  
Address 2812 Olive St Date signed 7/1/47

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

MOTHER FATHER

0  
7  
9

10  
2  
NR4  
1

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**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..... *Alex Campbell* .....

Licensed Embalmer No. *3881* .....

P. O. Address *4355 Washington Av* .....

**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, above space should be left blank.**