FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 8 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31986

Registration District No. 38 | Primary Registration District No. 3006 | Registrar's No. 271

1. PLACE OF DEATH:

(a) County: Boone

(b) City or town: Columbia (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2 Clinkscales Rd. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... In this community 19 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Boone

(c) City or town: Columbia (If outside city or town limits, write "RURAL")

(d) Street No.: 2 Clinkscales Rd. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME: JESSE WILLIS COATES

3. (b) If veteran, name war: World War II

3. (c) Social Security No.: .....

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Single

6. (b) Name of husband or wife: .....

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

7. Birth date of deceased: 8 (Month) - 11 (Day) - 1923 (Year)

8. AGE: Years	Months	Days	If less than one day
25	2	13	..... hr. ..... min.

9. Birthplace: Shidler (City, town, or county) Oklahoma (State or foreign country)

10. Usual occupation: Carpenter

11. Industry or business: .....

FATHER 12. Name: William Coates

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

MOTHER 14. Maiden name: Grace Shadrick

15. Birthplace: Oklahoma (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. William Coates

(b) Address: 2 Clinkscales Rd., Columbia, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-26-48 (Month) (Day) (Year)

(c) Place: burial or cremation: Memorial Park Cemetery

18. (a) Signature of funeral director: Parker Funeral Service

(b) Address: Columbia, Mo.

19. (a) 10-25-48 (Date received local registrar) (b) Mrs. R E Palmer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 24 year 1948 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from August 24, 1948, to Oct 24, 1948 that I last saw him alive on October 24, 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Sarcoma	5 months
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations: 55F
Of autopsy:

PHYSICIAN — Underline the cause of which death should be charged statistically.

ADDITIONAL INFORMATION REQUESTED

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: Charles A. Leech Jr (M. D. or other) MD

Address: Columbia, Mo Date signed 10-25-48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

No. 2 /47 7-39

RECEIVED
District Health Officer No. 9,
District File Number NOV 5 1948
Date Filed NOV 17 1948
DEC 17 1948
DEC 30

AUG 18 1955

NOV 16 1948

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 Tom McLong

Licensed Embalmer No. 4067

P. O. Address Columbia, 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.

2B
3-45
X43880

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

State File No. Nov. 271

Registration District No. 38 Primary Registration District No. 3006 Registrar's No.

1. PLACE OF DEATH:

(a) County
(b) City or town Boone Columbia
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME June W. 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 S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug 11 1923 (Month) (Day) (Year)
8. AGE: Years 25 Months 2 Days 13 Unless than one day hr. min.
9. Birthplace (City, town, or county) Okla. (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 4 year 1948 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations primary fibrosarcoma right vastus lateralis
Of autopsy

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

SUPPLEMENTARY

5-31984