

FILED JAN 26 1949

THE DIVISION OF HEALTH - MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2074

REG. DIST. NO. 272 PRIMARY REG. DIST. NO. 4398 Registrar's No. 6

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Dr. Callahan

1. PLACE OF DEATH a. COUNTY <u>Remount</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Remount</u>	
b. CITY OR TOWN <u>Holland</u>		c. CITY OR TOWN <u>Holland</u>	
c. LENGTH OF STAY (In this place) <u>45 yrs</u>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION		4. DATE OF DEATH (Month) (Day) (Year) <u>1-12-49</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u> b. (Middle) <u>Edward</u> c. (Last) <u>Coburn</u>	5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>4-9-1880</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Falsonville Ind</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>John W Coburn</u>	13b. MOTHER'S MAIDEN NAME <u>unknow</u>	14. NAME OF HUSBAND OR WIFE <u>Anna Coburn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Joe Coburn Holland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4/20</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June</u> , 1948, to <u>Jan 12</u> , 1949, that I last saw the deceased alive on <u>Jan 12</u> , 1948, and that death occurred at <u>11:30 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>J. M. Callahan D.O.</u>		23b. ADDRESS <u>Steele, Mo</u>	23c. DATE SIGNED <u>1/18/49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>	24b. DATE <u>1-14-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>City Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Sikeston, Mo</u>
DATE REC'D BY LOCAL REG. <u>1-26-49</u>	REGISTRAR'S SIGNATURE <u>S. P. ...</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hermon ... Steele Mo</u>	

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

1-49-37

**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.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*John H. German*

Licensed Embalmer No.

*4355*

P. O. Address

*Stagite, 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.