

FILED MAY 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18296

BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 66

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lilbourn</u>	
c. LENGTH OF STAY (in this place) <u>36 hrs</u>		d. STREET ADDRESS (If rural, give location) <u>Gen'l Delivery</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Mo. Delta Comm. Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Lonnie</u> b. (Middle) <u>D.</u> c. (Last) <u>Coggain</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 16 1949</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>March 15-1943</u>	9. AGE (In years last birthday) <u>6</u>	10. UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	10. UNDER 24 HRS. Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Conran, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Robert Coggain, dec.</u>	13b. MOTHER'S MAIDEN NAME <u>Irene Taylor</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Irene Coggain, Lilbourn, Missouri</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Contusion of brain</u>		<u>36 HRS</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) _____		<u>E 8124</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>25.</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> (Specify) <u>Accident</u>	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) <u>May 14 49th P.m.</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>STRUCK BY Automobile</u>

22. I hereby certify that I attended the deceased from MAY 14 1949, to May 16 1949, that I last saw the deceased alive on May 15 1949, and that death occurred at 2nd A^m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Wm. C. Citchlaw M.D.</u>	23b. ADDRESS <u>Stalling Bldg. Sikeston, Mo.</u>	23c. DATE SIGNED <u>May 16, 1949</u>
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24a. BURIAL, CREMATION REMOVAL (Specify)	24b. DATE <u>May 18 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Land Hill</u>	24d. LOCATION (City, town, or county) (State) <u>New Madrid, MO.</u>
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DATE REC'D BY LOCAL REG. <u>May 18-49</u>	REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ponder Funeral Home, Lilbourn, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Office No. 2

District File Number 549-627

Date Filed 5-23-49

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 Homer L. Ponder

Licensed Embalmer No. 3367

P. O. Address Lilbourn, 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.