

FILED AUG 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26106**
Registrar's No. **38**

BIRTH NO. _____ REG. DIST. NO. **37** PRIMARY REG. DIST. NO. **5116** Registrar's No. **38**

1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY BOONE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural - Bourbon		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL - Bourbon	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 5 mi S.W. Sturgeon	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED a. (First) Maud b. (Middle) Lee c. (Last) Coats			4. DATE OF DEATH (Month) (Day) (Year) Aug. 11 - 1949		
5. SEX F	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Apr. 29 - 1881		9. AGE (In years last birthday) 68 MONTHS 3 DAYS 10 HOURS MIN.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Kept.		11. BIRTHPLACE (State or foreign country) Boone Co. O	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME William R. Frost		13b. MOTHER'S MAIDEN NAME Martha Pickett		14. NAME OF HUSBAND OR WIFE George Coats	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. L		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Walt K. Sturgeon, Mo.	

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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Insufficiency		INTERVAL BETWEEN ONSET AND DEATH 5 days
	ANTECEDENT CAUSES also leg. bleed		
	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			4/10X

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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) m.		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 **Aug 11, 1949** to **Aug 11, 1949** that I, last saw the deceased alive on **Aug 11, 1949** and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE A. R. McBride (Degree or title)		23b. ADDRESS Sturgeon, Mo.		23c. DATE SIGNED Aug 12 - 49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug. 14 - 1949		24c. NAME OF CEMETERY OR CREMATORY Drippings Springs	
24d. LOCATION (City, town, or county) (State) Boone Co. Mo		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Barnes & Boothe - Sturgeon, Mo.			
DATE REC'D BY LOCAL REG. Aug 13 - 1949		REGISTRAR'S SIGNATURE Maud McBride			

(Licensed Embalmer's Statement on Reverse Side)

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

District File Number _____
District Health Officer No. 9
RECEIVED

AUG 16 1949 - 14114

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.

Signed _____
A. E. Boothe

Signed _____
Student Embalmer

Licensed Embalmer No. 4087

P. O. Address Sturgis 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.