

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. **238** PRIMARY REG. DIST. NO. **4355** Registrar's No. **64**

0721
1

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

1. PLACE OF DEATH a. COUNTY NEW MADRID.		2. USUAL RESIDENCE (Where deceased lived. If institution? residence before admission). a. STATE MISSOURI. b. COUNTY NEW MADRID.	
b. CITY (If outside corporate limits, write RURAL and give township) NEW MADRID.		c. CITY (If outside corporate limits, write RURAL and give township) NEW MADRID. 0721	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) ROBERT. b. (Middle) COBURN c. (Last) COBURN			4. DATE OF DEATH (Month) (Day) (Year) NOV-13-51		
5. SEX M. ♀		6. COLOR OR RACE COLORED		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	
8. DATE OF BIRTH JAN. 3-1895		9. AGE (In years last birthday) 56		10. IF UNDER 1 YEAR Months 10 Days 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LOUISVILLE MISS. 1	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME JACK COBURN		13b. MOTHER'S MAIDEN NAME LAURA HARRIS		14. NAME OF HUSBAND OR WIFE ELENORA COBURN	
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. 512-05-1982		17. INFORMANT'S SIGNATURE OR NAME ADDRESS ELENORA COBURN, NEW MADRID.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Subsidiary urinary tract		8 mo.	
ANTECEDENT CAUSES		DUE TO (b) congestive heart failure		12 mo.	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) severe hypertensive		12 mo.	
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		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) 016X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 **Dec**, 1951, to **5 NOV.**, 1951, that I last saw the deceased alive on **5 NOV.**, 1951, and that death occurred at **6 P.** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Charles C. Reeder M.D.		23b. ADDRESS New Madrid, Mo		23c. DATE SIGNED 15 Nov 51	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE NOV-16-51		24c. NAME OF CEMETERY OR CREMATORY SAND HILL	
24d. LOCATION (City, town, or county) (State) NEW MADRID. MO.					

DATE REC'D BY LOCAL REG. 11-16-51		REGISTRAR'S SIGNATURE Helen Louise Jones		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS RICHARD'S UND'T. Co. NEW MADRID	
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RECEIVED

NOV 20 1951

DISTRICT HEALTH OFFICE No. 6

File No.....

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 _____

Tommy G. Rohut Student Embalmer No. 424
working under my personal supervision.

Student Tommy G. Rohut Signed L. H. Haysmith
Student Embalmer

Licensed Embalmer No. 3803

P. O. Address New Medical Bldg

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.