

REC'D JUN 26 1952

BIRTH NO. _____ REG. DIST. NO. 157 PRIMARY REG. DIST. NO. 5587 Registrar's No. 113

490
1

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

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived) If institution: residence before admission. a. STATE Mo b. COUNTY Jasper	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Reeds Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Reeds Mo (0490)	
d. FULL NAME OF HOSPITAL OR INSTITUTION R 7 D 1 Home		d. STREET ADDRESS (If rural, give location) Saroyie Suph	

3. NAME OF DECEASED (Type or Print) a. (First) H. L. (Doc) b. (Middle) c. (Last) Coates			4. DATE OF DEATH (Month) (Day) (Year) 6-17-52		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1-30-1892	9. AGE (In years last birthday) 60	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
11. BIRTHPLACE (City and State or Foreign Country) Reeds Mo		12. CITIZEN OF WHAT COUNTRY? U.S.			

13a. FATHER'S NAME Wm Coates	13b. MOTHER'S MAIDEN NAME Ellen Ward	14. NAME OF HUSBAND OR WIFE Sophia Coates
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. [check]	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sophia Coates, Reeds 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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction.		INTERVAL BETWEEN ONSET AND DEATH 10 days 15 min 20 yrs 20 yrs
	ANTECEDENT CAUSES DUE TO (b) Myocardial Infarction		
	DUE TO (c) Coronary Thrombosis.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension Arterial Bronchial Asthma			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4201	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	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 4-25 1952 to 6-17 1952, that I last saw the deceased alive on 6-17 1952 and that death occurred at 7:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE M. Nordstrom, M.D.	23b. ADDRESS Emory, Mo.	23c. DATE SIGNED 6-19-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-19-52	24c. NAME OF CEMETERY OR CREMATORY Harvey Cem	24d. LOCATION (City, town, or county) (State) La Russell Mo
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DATE REC'D BY LOCAL REG. 6-19-52	REGISTRAR'S SIGNATURE L. B. Clutter	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jackson & Sons Saroyie Mo
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RECEIVED 6-24-52
Jasper County Health Office

County File Number 52/6/491
Date Filed 6-24-52

JUL 31 1952

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 *Wm K. Jackson*

Licensed Embalmer No. *3954*

P. O. Address *Sarcoxie 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.