

FILED JAN - 8 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3900 Registrar's No. 29

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Macon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville	c. LENGTH OF STAY (In this place) 2 days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN La Plata 0610	
d. FULL NAME OF HOSPITAL OR INSTITUTION Grim-Smith Memorial		d. STREET ADDRESS (If rural, give location) /	

3. NAME OF DECEASED (Type or Print)	a. (First) Olaf	b. (Middle) Franklin	c. (Last) Coons	4. DATE OF DEATH (Month) (Day) (Year) Jan. 22, 1953
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5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 7/18/1888	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer, Rtd.		10b. KIND OF BUSINESS OR INDUSTRY Farmer, Rtd.		11. BIRTHPLACE (City and State or Foreign Country) Schuyler County, Mo. C		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME Sigal Coons		13b. MOTHER'S MAIDEN NAME Ida Kaster		14. NAME OF HUSBAND OR WIFE Mrs. Maude Coons	
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Maude Coons		ADDRESS La Plata, Mo.	
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension, chronic DUE TO (c) 331X II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH 24 hours 2 yrs.
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)
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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?
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22. I hereby certify that I attended the deceased from Jan 21, 1953, to Jan 22, 1953, that I last saw the deceased alive on Jan 22, 1953 and that death occurred at 8:45 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M.D. [Signature]	23b. ADDRESS Kirksville, Missouri	23c. DATE SIGNED 1-23-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/25/53	24c. NAME OF CEMETERY OR CREMATORY Queen City	24d. LOCATION (City, town, or county) (State) Queen City, Mo.
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DATE REC'D BY LOCAL REG. 1-26-53	REGISTRAR'S SIGNATURE Kate Lambert 1-0	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Kirksville, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1953 FEB 3

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 Richard W. Randall

Licensed Embalmer No. 4866

P. O. Address Fishersville, 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.