

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28280

FILED SEP 14 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 842-D

4  
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Greene</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>mo</u> b. COUNTY <u>Dade</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield mo</u> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lockwood mo</u>                                    |  |
| c. LENGTH OF STAY (in this place) <u>3 mo.</u>   |  | d. STREET ADDRESS (If rural, give location) <u>1</u>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Jrotter Rest Home</u>                                   |  |  |  |

|  |                           |  |   |   |  |
|--|---------------------------|--|---|---|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>Nancy</u> b. (Middle) <u>Rosanna</u> c. (Last) <u>Coyne</u> |                           |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>Sept 2, 1953</u>      |   |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>Mar 1, 1866</u>                               | 9. AGE (In years last birthday) <u>87</u> | 10. UNDER 1 YEAR <u>6</u> 11. UNDER 11 HRS. <u>1</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>       |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>house work</u>                  | 11. BIRTHPLACE (State or foreign country) <u>Morning Sun Iowa</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 13a. FATHER'S NAME <u>Patrick Coyne</u>                                     |  | 13b. MOTHER'S MAIDEN NAME <u>Jane E. Smiley</u> |  | 14. NAME OF HUSBAND OR WIFE   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> |  | 16. SOCIAL SECURITY NO. <u>none</u>             |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><u>Henry Coyne Lockwood mo</u> |  |

|   |  |   |  |  |  |                                  |  |
|---|--|---|--|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Had 2 or 3 previous ones</u><br>DUE TO (c) <u>arterio sclerosis</u><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |  | INTERVAL BETWEEN ONSET AND DEATH |  |
|---|--|---|--|--|--|----------------------------------|--|

|                        |                                  |  |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 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)<br><u>331X</u> |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR?                                     |

22. I hereby certify that I attended the deceased from 8-25-53, 1953, to 9-2-53, 1953, that I last saw the deceased alive on 9/2, 1953, and that death occurred at 12:30 P. m., from the causes and on the date stated above.

|   |  |                                |
|---|--|--------------------------------|
| 23a. SIGNATURE (Degree or title) <u>Garrett Hagg M.D.</u> | 23b. ADDRESS <u>1053 Rowan - Springfield</u> | 23c. DATE SIGNED <u>9/5/53</u> |
|---|--|--------------------------------|

|   |                         |   |   |
|---|-------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>9-5-53</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Edgar</u> | 24d. LOCATION (City, town, or county) (State) <u>Dade Co mo</u> |
|---|-------------------------|---|---|

|  |   |  |
|--|---|--|
| DATE REC'D BY LOCAL REG. <u>9-9-53</u> | REGISTRAR'S SIGNATURE <u>Edith Williamson</u> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><u>W.P. Allison Greenfield, Mo</u> |
|--|---|--|

**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 *W.R. Allison* .....

Licensed Embalmer No. *4404* .....

P. O. Address, *Shepherd 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.