

FILED JAN 21 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **1122**  
Registrar's No. **11**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **140** PRIMARY REG. DIST. NO. **3024**

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Boone</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Fayette</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rocheport</b>	
c. LENGTH OF STAY (in this place) <b>14 days</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>Lee Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>Route # 1</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Andrew</b> b. (Middle) <b>E.</b> c. (Last) <b>Coats</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>January 12, 1954</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 1, 1895</b>	9. AGE (In years last birthday) <b>58</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Fulton Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>James A. Coats</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Furks</b>	14. NAME OF HUSBAND OR WIFE <b>Elizabeth Coats</b>
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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) <b>Yes W.W. 2</b>	16. SOCIAL SECURITY NO. <b>W.W. 2</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Elizabeth Coats, Rocheport, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <b>9-5-19 to 12-21-19</b>  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>cerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>  <b>?</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>hypertensive cardio-vascular disease</b> DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION <b>none</b>	19b. MAJOR FINDINGS OF OPERATION <b>443X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>natural</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, 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 **July, 1950**, to **Jan 12, 1954**, that I last saw the deceased alive on **Jan 12, 1954**, and that death occurred at **10:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>M. J. Shaw, Jr. M.D.</b>	23b. ADDRESS <b>Lee Hospital, Fayette, Mo.</b>	23c. DATE SIGNED <b>1-15-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Jan. 15, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>	24d. LOCATION (City, town, or county) (State) <b>Columbia, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>1-15-54</b>	REGISTRAR'S SIGNATURE <b>Mary K. Shell</b>	456	25. FUNERAL DIRECTOR'S SIGNATURE <b>Memorial Funeral Home</b>	ADDRESS <b>Columbia, Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 6

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, ~~only~~.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Lyman Sprinkle*

Licensed Embalmer No. 4013

P. O. Address Columbia, 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.