

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23572

BIRTH NO. _____ REG. DIST. NO. 178 PRIMARY REG. DIST. NO. 5664 Registrar's No. 55

560

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

1. PLACE OF DEATH a. COUNTY Lewis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Lewis	
b. CITY (If outside corporate limits, write RURAL and give town) Williamstown		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION		c. CITY (If outside corporate limits, write RURAL and give township) Williamstown	
		d. STREET ADDRESS (If rural, give location) 0	
3. NAME OF DECEASED (Type or Print) a. (First) Minnie		b. (Middle) Ann	
		c. (Last) Coney	
4. DATE OF DEATH (Month) (Day) (Year) 7 16 54		5. SEX F	
6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	
8. DATE OF BIRTH Feb. 22, 1902		9. AGE (In years last birthday) 52	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John Field		13b. MOTHER'S MAIDEN NAME Minnie Staniford	
14. NAME OF HUSBAND OR WIFE William Coney		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME William Coney, Williamstown, 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, ashenia, 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 Morbidity conditions, if any, giving rise to the above cause: (a) stating the underlying cause last. DUE TO (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		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? 331X 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		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 Jan 10, 1953 , to July 16, 1954 , that I last saw the deceased alive on July 16, 1954 , and that death occurred at 10:45 am. , from the causes and on the date stated above.	
23a. SIGNATURE Dr. C. E. Todd (Degree or title)		23b. ADDRESS 602 Williamstown Mo	
23c. DATE SIGNED 7/17/54		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 7-18-54		24c. NAME OF CEMETERY OR CREMATORY Liberty Cemetery	
24d. LOCATION (City, town, or county) (State) Clark County, Mo.		DATE REC'D BY LOCAL REG. 7-20-54	
REGISTRAR'S SIGNATURE P. W. Jennings		25. FUNERAL DIRECTOR'S SIGNATURE Burth + Burshel ADDRESS Wyaconda, Mo.	

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Geo V. Bosket

Signed.....
Student Embalmer

Licensed Embalmer No. *1817*

P. O. Address *Wyalondam*

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.