

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

BIRTH NO. ....

REG. DIST. NO. ....

318

PRIMARY REG. DIST. NO. ....

1003

10553

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 5 days	c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. John's Hospital			e. STREET ADDRESS (If rural, give location) 3 6528 Mardel 2039		
3. NAME OF DECEASED (Type or Print) a. (First) Henry b. (Middle) David c. (Last) Koonce			4. DATE OF DEATH (Month) (Day) (Year) Nov. 19, 1954		
5. SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 24, 1873	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receiving Clerk		10b. KIND OF BUSINESS OR INDUSTRY Merchandise Co.	11. BIRTHPLACE (City and State or Foreign Country) Nashville, Arkansas		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME William Koonce		13b. MOTHER'S MAIDEN NAME Mariah McElroy		14. NAME OF HUSBAND OR WIFE Anna Koonce	
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. 490-01-6519	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Anna Koonce, 6528 Mardel, 9		
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.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <u>19 days</u> <u>2 years</u>
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) <u>4201</u>		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 <u>Nov 1</u> , 19 <u>54</u> , to <u>Nov 19</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>Nov 19</u> , 19 <u>54</u> , and that death occurred at <u>12:15 p.m.</u> , from the causes and on the date stated above.					
23a. SIGNATURE <u>John S. Matthew M.D.</u> (Degree or title)			23b. ADDRESS <u>3707 Watson Rd</u>		23c. DATE SIGNED <u>11-19-54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Nov. 20, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>County Line Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Nashville Arkansas</u>	
DATE REC'D BY LOCAL REG. <u>NOV 19 1954</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C. Hoffmeister Colonial Mortuary, Chippewa</u>	

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

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.....  
Signature of Student Embalmer

Signed *Linus C. Hoffmeister*.....

Licensed Embalmer No. *3871*.....

P. O. Address *7814 S. Br*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.