

FILED SEP 26 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHDR. RUSSELL
State File No. 29523

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5465 Registrar's No. 825

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|---|--|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY GREENE | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). b. STATE MISSOURI | |
| b. CITY (If outside corporate limits, write RURAL and give town(ship)) OR TOWN SPRINGFIELD Rural | | c. LENGTH OF STAY (in this place) 8 YRS. | c. CITY OR TOWN SPRINGFIELD |
| d. FULL NAME OF HOSPITAL OR INSTITUTION GREENE COUNTY FARM | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| e. STREET ADDRESS GREENE COUNTY FARM | | (If rural, give location) 0390 | |

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|---|----------------------------------|--|---|--------------------|--|
| 3. NAME OF DECEASED (Type or Print) | | | 4. DATE OF DEATH | | |
| a. (First) ALBERT | b. (Middle) | c. (Last) COATES | (Month) SEPT. | (Day) 17 | (Year) 1955 |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED | 8. DATE OF BIRTH MAY 12 1870 | | 9. AGE (In years last birthday) 85 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY HATTER | 11. BIRTHPLACE (City and State or Foreign Country) ARKANSAS | | 12. CITIZEN OF WHAT COUNTRY? USA |

| | | |
|---|---|---|
| 13a. FATHER'S NAME UNKNOWN | 13b. MOTHER'S MAIDEN NAME UNKNOWN | 14. NAME OF HUSBAND OR WIFE GOLDA COATES (DECEASED) |
| 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. ? | 17. INFORMANT'S SIGNATURE OR NAME COUNTY FARM RECORDS |
| | | ADDRESS SPRINGFIELD, 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 | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of prostate | | |
| | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 177X | | |
| 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) |
| 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 Sept 3, 1955 to Sept 17, 1955, that I last saw the deceased alive on Sept 17, 1955, and that death occurred at 6:25 P.M. from the causes and on the date stated above.

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|--|--|---|---|
| 23a. SIGNATURE David H. Hall M.D. | Degree or title | 23b. ADDRESS Springfield, Missouri | 23c. DATE SIGNED 9/21/55 |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 24b. DATE 9/21/55 | 24c. NAME OF CEMETERY OR CREMATORY MAPLE PARK | 24d. LOCATION (City, town, or county) (State) SPRINGFIELD, MISSOURI |
| DATE REC'D BY LOCAL REG. 9-21-55 | REGISTRAR'S SIGNATURE Edith Williamson | 25. SIGNATURE OF DIRECTOR Dr. Russell | ADDRESS SPRINGFIELD, MO. |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING 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..... *Gene A. Hunt*

Licensed Embalmer No. *473*

P. O. Address *Spring*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fails 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.