

FILED MAY 6 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

12764

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 399-A

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Greene</b>		a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		c. CITY OR TOWN <b>Springfield</b> <b>0396</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St John's Hospital</b>		d. STREET ADDRESS <b>832 S. Kimbrough</b>	
Length of stay in 1b <b>30 yrs</b>		Reside on Farm <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH				
First <b>WALTER</b> Middle <b>A.</b> Last <b>COON</b>			Month <b>April</b> Day <b>25</b> Year <b>1957</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 18, 1872</b>		9. AGE (In years last birthday) <b>85</b>		
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		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) <b>Ret. Chairman Board Dir.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Union Nat. Bank</b>		11. BIRTHPLACE (City and state or country) <b>Urbana, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William B. Coon</b>			14. MOTHER'S MAIDEN NAME <b>Harriett V. Andrews</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>494-18-9152</b>		17. INFORMANT <b>Mrs Myra Coon, Springfield, Missouri</b>			
(If yes, give war or dates of service)		Address					

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <b>18 mo.</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____	
		DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		<b>4200</b>	

20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____	

21. I attended the deceased from <b>2-17-57</b> to <b>4-25-57</b> and last saw <sup>him</sup> alive on <b>4-25-57</b> Death occurred at <b>5:10 a.m.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Dr. P. Moadley M.D.</b>		22b. ADDRESS <b>609 Cherry Springfield, Missouri</b>		22c. DATE SIGNED <b>4-29-57</b>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 27, 1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maple Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Springfield, Missouri</b>	
24. FUNERAL DIRECTOR <b>Jewell E. Windle B.W.</b> ADDRESS <b>Springfield, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>5-3-57</b>		26. REGISTRAR'S SIGNATURE <b>Edith Williamson</b>		

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health, &amp; Welfare Public Service

300 1-56

MAY 13 1957

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 *Bernard F. Wright*

Licensed Embalmer No. *42*

P. O. Address *Springfield*

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.