

Health,  
Welfare  
Public  
Service

300  
1-56 0

diseases in Part I must be causally related. Caregiver cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JUN 17 1957

STANDARD CERTIFICATE OF DEATH

20955

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 656

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph 0117 0
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Meth. Hosp.		Length of stay in lb 60 years	d. STREET ADDRESS (If outside, give location) 2323 So. 17th St.
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last LEONE E. COKER			4. DATE OF DEATH Month Day Year June 8, 1957		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1877	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and state or country) Stevenson County, Ill.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James C. Beam			14. MOTHER'S MAIDEN NAME Mary E. Baysinger		
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. none	17. INFORMANT Address Joseph Coker, 2323 So. 17th St. Joseph, Mo.		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Hypostatic		INTERVAL BETWEEN ONSET AND DEATH 7 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cerebral Thrombosis	17 days
	DUE TO (c) Arteriosclerosis	Unknown
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

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 Month, Day, Year 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 25 May 57 to 8 June 57 and last saw her alive on 8 June 57 Death occurred at 7:36p. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) L. M. Matherhead M.D.			22b. ADDRESS 2603 Fremont City	22c. DATE SIGNED 6-12-57	

23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) burial	23b. DATE 6/11/1957	23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
24. FUNERAL DIRECTOR Heaton-Bowman Funeral Home, St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. June 14, 1957	26. REGISTRAR'S SIGNATURE Kathleen M. Allison

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em  
by me, or by ..... Student Embalmer No. ....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Billie C. Gonder*.....

Licensed Embalmer No. *490*

P. O. Address *St. Louis, Mo.*

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