

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

45470  
STATE FILE NUMBER

FILED JAN 7 1958

Registration District No. 314 Primary Registration District No. 6064 Registrar's No. 1

1. PLACE OF DEATH a. COUNTY <b>ST CLAIR</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>ST CLAIR</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>OSCEOLA</b>		c. CITY OR TOWN <b>OSCEOLA</b> <b>093</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>SARAH ELLEN COONES</b>			4. DATE OF DEATH Month Day Year <b>12-23-57</b>		
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>OCT 20, 1886</b>	9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPING</b>	10b: KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>ARKANSAS</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
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13a. FATHER'S NAME <b>ALFRED ROMINE</b>	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>C.A. Woodward</b>	Address <b>OSCEOLA, MO</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR OCCLUSION</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>CEREBRAL ARTERIOSCLEROSIS</b>	<b>UNKNOWN</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) <b>332X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from <b>JUNE 1955</b> to <b>DEC 23 1957</b> and last saw her alive on <b>12-23-57</b> Death occurred at <b>11:30 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>H. L. Shipman</b> (Degree or title) <b>D.O.</b>	22b. ADDRESS <b>Osceola, Mo.</b>	22c. DATE SIGNED <b>12-23-57</b>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE <b>12-27-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OSCEOLA</b>	23d. LOCATION (City, town, or county) (State) <b>OSCEOLA MO</b>
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24. FUNERAL DIRECTOR <b>Goodrich Home</b>	ADDRESS <b>OSCEOLA MO</b>	25. DATE RECD. BY LOCAL REG. <b>1-3-58</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Seewers</b>
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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *J.B. Baalwick* .....

Licensed Embalmer No. *3038* .....

P. O. Address *Aspen, Mo* .....

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.