

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-029398
STATE FILE NUMBER

FILED AUG 19 1958 Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 390

S. 300
1-57

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|--|-----------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY JASPER | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JASPER | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JOPLIN | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN JOPLIN 0495 0 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION JOPLIN GENERAL HOSP. | | Length of stay in lb 70 YRS | d. STREET ADDRESS (If outside, give location) 2012 JOPLIN ST. | | Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last STELLA EUNICE COON | | | 4. DATE OF DEATH Month Day Year AUGUST 7, 1958 | | |
| 5. SEX F 1 | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH SEPT. 4, 1880 | 9. AGE (In years last birthday) 77 | 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) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | 11. BIRTHPLACE (City and state or country) PARSONS, Ks. 1 | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13a. FATHER'S NAME ART HILL | | 13b. MOTHER'S MAIDEN NAME MARY JOHNSON | | 14. NAME OF HUSBAND OR WIFE JOHN P. COON, DECD 1936 | |
| 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 DAU- MRS. LETHA HIGGINS, 2012 JOPLIN ST. Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute medullary failure</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 hrs. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Rupture of Charcot's Artery of Hemorrhage</u> | | | | | 2 P.M. |
| DUE TO (c) <u>Generalized arteriosclerosis</u> | | | | | unknown |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Glomerulo Nephritis</u> | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 1 |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <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 <u>8/5/58</u> to <u>8/7/58</u> and last saw ^{her} _{him} alive on <u>8/7/58</u> Death occurred at <u>6:15 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <i>W. E. Silbano M.D.</i> | | | 22b. ADDRESS 521 W. 4th., Joplin, Mo. | | 22c. DATE SIGNED 8/9/58 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 8-9-58 | 23c. NAME OF CEMETERY OR CREMATORY FOREST PARK CEMETERY, | 23d. LOCATION (City, town, or county) (State) JOPLIN, MISSOURI | | |
| 24. FUNERAL DIRECTOR STEVE PARKER MORTUARY, JOPLIN, MO. | | ADDRESS | 25. DATE RECD. BY LOCAL REG. 8-12-1958 | 26. REGISTRAR'S SIGNATURE <i>Dove Merriam</i> | |

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 *F. M. Jones*

Licensed Embalmer No. *2319*

P. O. Address *Joplin 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.