

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016393  
STATE FILE NUMBER

FILED MAY 11 1959

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 81

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Saline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Cooper</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Marshall</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Blackwater</b> 0270 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <del>HOSPITAL</del> <b>John Fitzgibbon</b>		Length of stay in 1b <b>1-mo.</b>	d. STREET ADDRESS (If outside, give location) <b>P.O. Box 95</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>Coates</b> Last <b>Coates</b>			4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>59</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10th 1882</b>	9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) <b>Howard County, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>John Coates</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Elizebeth Hawkins</b>	14. NAME OF HUSBAND OR WIFE <b>Unknown</b>
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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>George Coates, Blackwater, Missouri</b>	Address
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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>Myelogenous leukemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2041</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)		

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.) <b>2041</b>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION	COUNTY	STATE
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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>6 April 1958</b> to <b>5 May 1959</b> and last saw him alive on <b>5 May 1959</b> Death occurred at <b>7:00 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Robert W. Oldenkamp</b>	22b. ADDRESS <b>370 S. Odell</b>	22c. DATE SIGNED <b>6 May 1959</b>
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23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>May 9, 1959</b>	23c. NAME OF CEMETERY OR CREMATORIAL HOME <b>Nelson, Missouri</b>	23d. LOCATION (City, town, or county) (State) <b>Saline County, Missouri</b>
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24. FUNERAL DIRECTOR <b>George H. Green, Marshall Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>5-9-59</b>	26. REGISTRAR'S SIGNATURE <b>Coil J. Reed</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 .....

Licensed Embalmer No. 4320

P. O. Address Marshall 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.