

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

148 = 62-027750

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 384 Primary Registration District No. 3097 Registrar's No. 148

FILED JUL 31 1962

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>Linn</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Carroll</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Brookfield</b>		Length of stay in 1b <b>3 days</b>	c. CITY OR TOWN <b>Hale,</b>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Pershing Memorial Hospital</b>		Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>East part town</b>
3. NAME OF DECEASED (Type or print) First <b>CYRIL</b> Middle <b>T.</b> Last <b>COONS</b>		4. DATE OF DEATH Month <b>July</b> Day <b>18th</b> Year <b>1962</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Livestock &amp; Grain</b>	11. BIRTHPLACE (City and state or country) <b>Rothville, Mo.</b>
13a. FATHER'S NAME <b>Thomas T. Coons,</b>		13b. MOTHER'S MAIDEN NAME <b>Lillie Wheelbarger,</b>	
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. <b>No</b>	
17. INFORMANT <b>Martin Coons, Hale, Mo. RFD</b>		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) <b>Respiratory arrest</b> DUE TO (b) <b>Cerebral vascular accident</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	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.) <b>F.H.</b>		20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>11:40 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>H.W. Schulz M.D.</b>		22b. ADDRESS <b>Brookfield, Mo.</b>	22c. DATE SIGNED <b>7-20-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7/21/1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lakeside Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Sumner, Missouri.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Clifford W. Austin F-H Hale, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>7-21-62</b>	26. REGISTRAR'S SIGNATURE <b>Anna Watson</b>

FEB 19 1963  
AUG 3 1962

**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 *Clifford W Austin*  
Licensed Embalmer No. #3233

P. O. Address Tina, Missouri.

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.