N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

REC'D JUN 12 1939

791

16643
Do not use this space.

1. PLACE OF DEATH
(a) County 1 Registration District No. 1003
(b) Township 2 Primary Registration District No. Registered No. 4177
(c) City St. Louis, Mo. (d) Street No. BARNES HOSPITAL St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 560 William Lowell Coomer
(a) Residence, No. 28 Ferndale St. NR Fort Smith, Arkansas
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Florence Martin Coomer

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 12 - 1905

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
34	3	22	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Auto Dealer
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fort Smith Arkansas

FATHER
13. NAME John Curtis Coomer
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Columbia Ky.

MOTHER
15. MAIDEN NAME Maggie Francis Williams
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Van Buren Arkansas

17. INFORMANT (ADDRESS) Mrs. Florence Coomer 28 Ferndale, Fort Smith, Ark.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Fort Smith, Ark. DATE May 4th 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) C. R. Lupton + Sons 7233 Delmar, University City

20. FILED MAY 4 1939 J. F. Budeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-4-39, 19

22. I HEREBY CERTIFY, That I attended deceased from 5-3-39, 19, to 5-4-39, 19
I last saw him alive on 5-4-39, 19 Death is said to have occurred on the date stated above, at 12 30 P.m.
The principal cause of death and related causes of importance were as follows:

bacterial endocarditis — Date of onset 4-15-39

115 C

Other contributory causes of importance: Non diphtheretic streptococcus sore throat and septicemia

Name of operation Date of
What test confirmed diagnosis? autopsy Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Cyril M. McBryde, M. D.
(Address) BARNES HOSPITAL

(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 embalmed by me, ...

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed Clarence H Murray

Licensed Embalmer No. 4011

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.