

AUG 4 1939

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

25211
Do not use this space.

1. PLACE OF DEATH *Callaway 3*

(a) County *Callaway* Registration District No. *104*

(b) Township *Fullon 1* Primary Registration District No. *3008* Registered No. *189*

(c) City *Fullon* (d) Street No. *State Hosp #1* St.

(e) Length of residence in city or town where death occurred yrs. *1* mos. *23* da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME *Tom Coats*

(a) Residence, No. *Moberly, Mo* St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M*

4. COLOR OR RACE *C*

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *M*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Mandy Coats*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 24, 1855*

7. AGE YEARS *84* MONTHS *8/83* DAYS *10* | *17* | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc. *Labour*

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 11th, 1939*

22. I HEREBY CERTIFY, That I attended deceased from *July 18*, 19*39*, to *July 11th*, 19*39*

I last saw him alive on *July 11*, 19*39* Death is said to have occurred on the date stated above, at *11:35 Am*.

The principal cause of death and related causes of importance were as follows:

*Senility
Pst. emb. S. S. § 4*

Date of onset

Other contributory causes of importance:
*Hypostatic pneumonia
Oligodactylia
Malnutrition*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

FATHER

13. NAME *Green Coats*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ky.*

MOTHER

15. MAIDEN NAME *Unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

17. INFORMANT (ADDRESS) *State Hosp #1 - Nevada Fullon Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Moberly Mo* DATE *July 16, 1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *J. H. Coats Moberly Mo*

20. FILED *July 13, 1939* *R. W. Crews - Local Registrar.*

Name of operation _____ Date of _____

What test confirmed diagnosis? *toxy* Was there an autopsy? _____

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) *Geo. F. Wood*, M. D.
(Address) *State Hosp #1 Fullon Mo*

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.

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.....

Licensed Embalmer No.....

P. O. Address.....

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