DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 11 1940

Registration District No. 744

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7899

Primary Registration District No. 3035

Registrar's No. 279-18

1. PLACE OF DEATH:

(a) County: Ray

(b) City or town: Richmond (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Richmond Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Ray

(c) City or town: Rural (If outside city or town limits, write "RURAL")

(d) Street No. 5 miles south of Orrick (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Callie May Coons

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Female

5. Color or race: white

6. (a) Single, widowed, married, divorced: married

6. (b) Name of husband or wife: Henry Clay Coons

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased: February (Month) 6 (Day) 1888 (Year)

8. AGE: Years 52 | Months 11 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace: near Orrick (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER 12. Name: Unknown

FATHER 13. Birthplace (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Henry Clay Coons

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 7 1940 (Month) (Day) (Year)

(c) Place: burial or cremation: South Point

18. (a) Signature of funeral director: Gibson & Son

(b) Address: Orrick

19. (a) 2/6/40 (Date received local registrar) (b) Mabel Jackson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 5 year 1940 hour 1 minute 15 P. M.

21. I hereby certify that I attended the deceased from Feb 1, 1940 to Feb 5, 1940; that I last saw h. ex alive on Feb 5, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary embolus	
Due to: Post operative (hysterectomy)	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: Fibromyoma uteri	
Of autopsy: none done	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

(e) While at work? (f) Means of injury

23. Signature: H. M. Griffith (M. D. or other)

Address: Richmond, Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Rev. 5-17-39 — 1 x19811

RECEIVED
District Health Officer No. 8
File Number 318740

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 E. C. Gibson

Licensed Embalmer No. 4137

P. O. Address Orrick, 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 this body is not embalmed, above space should be left blank.

2B
10
2659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7899

Registration District No. 744 Primary Registration District No. 3035 Registrar's No.

1. PLACE OF DEATH:
(a) County Ray
(b) City or town Richmond
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Callie May Coons
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased Feb 6 1888 (Month) (Day) (Year)

8. AGE: Years 51-52 Months 11 Days 29 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) Feb 26-40 (Date received local registrar) (b) Mabel Jackson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 5 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature H. M. Griffith (M. D. or other)
Address Richmond Mo Date signed

SUPPLEMENTARY