

No. 2  
1-4-41  
17-39  
22390

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 73

Primary Registration District No. 5112

Registrar's No. 149

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

1. PLACE OF DEATH

(a) County Boone

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

(c) Name of hospital or institution Boone Co. Infirmary  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9-1-41  
(Specify whether in this community years, months or days) all of life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

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

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Boone Coats

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 1  
year 1941 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from Feb 1  
1932 to June 1 1941  
that I last saw him alive on May 10 1941  
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased 4 — 8 — 1882  
(Month) (Day) (Year)

Immediate cause of death Diabetes Mellitus Duration 5 yrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

8. AGE: Years 59 Months 1 Days 23  
If less than one day hr. min.

Other conditions Hemorrhage rt. foot 2 mos  
(Include pregnancy within 3 months of death)  
due to diabetes

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

9. Birthplace Boone Co., Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Shoe Operator

11. Industry or business \_\_\_\_\_

12. Name Abner Coats

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

14. Maiden name Sarah Gordon

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Kohlenhaefer

(b) Address Sturgeon, Mo.

17. (a) Burial (b) Date thereof 6-3-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dripping Springs

18. (a) Signature of funeral director Parker

(b) Address Columbia, Mo.

19. (a) 6/3/41 (b) Allie Selby  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature A. W. Kampachmidt (Date) \_\_\_\_\_

Address Columbia, Mo. Date signed 6/1/41

19532-41

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**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, fact should be so stated above.**