

FILED APR 22 1942

Registration District No. 160 B

Primary Registration District No. 6001

Registrar's No. 163

1. PLACE OF DEATH:

(a) County St. Charles  
(b) City or town Ozark Mo  
(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)  
In this community 14 months years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette  
(c) City or town Wellington Mo  
(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.? 1 years.

3. (a) PRINT FULL NAME JOHN W. COATES

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W  
6. (b) Name of husband or wife Francis Coates 6. (c) Age of husband or wife if alive 63 years  
7. Birth date of deceased Sept 23 1868 (Month) (Day) (Year)

8. AGE: Years 73 Months 5 Days 28 If less than one day hr. \_\_\_\_\_ min.

9. Birthplace Sweet Springs Mo (City, town, or county) (State or foreign country)

10. Usual occupation Coal miner

11. Industry or business

MOTHER FATHER { 12. Name Joe Coates  
13. Birthplace not known (City, town, or county) (State or foreign country)  
14. Maiden name Jessie  
15. Birthplace not known (City, town, or county) (State or foreign country)

16. (a) Informant Eddie L. Coates (b) Address Ozark Mo

17. (a) Bessie (b) Date there 3-24-42 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wellington Mo

18. (a) Signature of funeral director Ray Egan (b) Address Wellington Mo

19. (a) 3-24-42 (b) B. A. Keithly (Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20 year 1942 hour 7 minute 0 M.

21. I hereby certify that I attended the deceased from March 1 1942 to March 20 1942 that I last saw him alive on March 18 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral anoxia Duration 1 yr.

Due to Primary lobe of Hemiplegia 6 yr.

Due to 46

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) No

(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 Raymond Gleason (M. D. or other) Address St. Charles Mo Date signed 3/24/42

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

72  
0  
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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 \_\_\_\_\_

*E. Keithly*

Licensed Embalmer No. \_\_\_\_\_

*877*

P. O. Address \_\_\_\_\_

*Dallas Mo.*

**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.**