

FILED MAR 10 1943  
Registration District No. **182**

Primary Registration District No. **5679**

1. PLACE OF DEATH:

(a) County **Living New Boston**  
(b) City or town **New Boston**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **None**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME **Kenneth Coram**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, (widowed), married, divorced **2**

6. (b) Name of husband or wife **Estlin Coram drcd** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **Dec 12 1852**  
(Month) (Day) (Year)

8. AGE: Years **90** Months **2** Days **2** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Eng South**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

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

12. Name **Mr Coram**

13. Birthplace **Eng South**  
(City, town, or county) (State or foreign country)

14. Maiden name **Charlott**

15. Birthplace **Eng South**  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Charley Coram**  
(b) Address **New Boston Mo**

17. (a) **Burial** (b) Date thereof **Feb 21 43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Newton Chapel**

18. (a) Signature of funeral director **Walter Rallin**  
(b) Address **Brookfield Mo**

19. (a) **2/22/43** (b) **Wesley Montgomery**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Living**  
(c) City or town **New Boston**  
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ day \_\_\_\_\_  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from **Feb 14**, 19**43**, to **Feb 18**, 19**43**;  
that I last saw him alive on **Feb 18**, 19**43**;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Sanity**

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

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

Other conditions **Nephritis**  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

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

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) (a) Means of injury \_\_\_\_\_

23. Signature **G.R. McArthur** (M. D. or other) **M.D.**  
Address **Browning** Date signed **2-20-43**

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING 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.

---

---

**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 *L. W. Collins*.....

Licensed Embalmer No. *1144*.....

P. O. Address *Brewfield MS*.....

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

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

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Linn  
(b) City or town New Boston  
(If outside city or town limits, write "RURAL" and name of town)  
(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 \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Wenford Caram  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race rr 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Dec 12 (Month) (Day) (Year)

8. AGE: Years 90 Months 2 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) (Specify whether \_\_\_\_\_)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn  
(c) City or town New Boston  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 18 Year 1943 Hour \_\_\_\_\_ Minute \_\_\_\_\_

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, that I saw him/her alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

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

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

Other conditions chronic nephritis  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

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

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) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

6874