

FILED JAN 17 1944

Registration District No. 274

Primary Registration District No. 5835

Registrar's No. 35

1. PLACE OF DEATH:

(a) County Newton  
 (b) City or town Joplin (RURAL)  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Luke's Hospital, 2nd St.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution..... (Specify whether  
 In this community 50 yrs  
 years, months or days)

3. (a) PRINT FULL NAME WILLIAM G. COY  
 3. (b) If veteran, name war..... 3. (c) Social Security No. none

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife Walter Coy 6. (c) Age of husband or wife if alive 20 years  
 7. Birth date of deceased 2 20 1871  
 (Month) (Day) (Year)

8. AGE: Years 72 Months 10 Days - If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER  
 12. Name Unknown  
 13. Birthplace Unknown (City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Golden H. Sched  
 (b) Address Neosho P.M.

17. (a) Burial (b) Date thereof 12-26-43  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hornet  
 18. (a) Signature of funeral director W. B. Buzzard  
 (b) Address Seneca Mo.

19. (a) 12-28-1943 (b) Mrs. U. S. Chapman  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton  
 (c) City or town Joplin  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 142nd St.  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20  
 year 1943 hour 10 minute 20 P.M.  
 21. I hereby certify that I attended the deceased from Dec 16  
 1943, to Dec 20, 1943;  
 that I last saw him alive on Dec 17, 1943;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Obstruction Duration 21 days

Due to Carcinoma Cecum  
 et Liver

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations H&E  
 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?  
 While at work? (Specify type of place) (e) Means of injury.....

23. Signature P. A. Mahony (M. D. or other) D.O.  
 Address Joplin, Mo. Date signed 12/27/43

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

13N

RECEIVED 1-5-44

District Health Officer No. -----

District File Number 1243-244 -----

Date Filed 1-10-44 -----

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

*W. T. Buzzard*

Licensed Embalmer No. 2334

P. O. Address *Seneca, 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, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

Registration District No. 244Primary Registration District No. 5835-1

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

## 1. PLACE OF DEATH:

(a) County Newton  
(b) City or town Rural  
(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

In this community \_\_\_\_\_ (Specify whether  
years, months or days)3. (a) PRINT  
FULL NAME Wm C. Coy3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. \_\_\_\_\_4. Sex m 5. Color or  
race w 6. (a) Single, widowed, married,  
divorced w6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years7. Birth date of deceased Feb. 20 1878  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
72 10 min.9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country) mo.

## 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

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

## 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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 20  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ 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 sta-  
tistically.

## 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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

3726