

S. No. 2
M-8-43
5-17-39
K37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8526**
Registrar's No. **1249**

FILED APR 5 1945
Registration District No. **789**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Research Hosp.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 Days
(Specify whether years, months or days)
 In this community No 5 days

3. (a) PRINT FULL NAME James Dudley Coons
 3. (b) If veteran, name war No
 3. (c) Social Security name None

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Pearl May Coons
 6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased Dec. 30th 1879
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>2</u>	<u>18</u>	hr. min.

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

10. Usual occupation Farmer

11. Industry or business Self

12. Name Edward Coons

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

14. Maiden name Elizabeth Thompson

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

16. (a) Informant Pearl Coons

(b) Address Norborne Missouri

17. (a) Burial (b) Date thereof 3/21/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Antioch Cem. Norborne Mo.

18. (a) Signature of funeral director Earp Funeral Home
 (b) Address 4139 East 15th. St.

19. (a) 3-18-45 (b) T. E. Brown (V3)
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Cassion 17
 (c) City or town Norborne
(If outside city or town limits, write "RURAL")
 (d) Street No. R. R. No 1
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 18th
 year 1945 hour 12 minute 15 A. M.

21. I hereby certify that I attended the deceased from March 13th 1945 to March 17th, 1945.

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 Strangulated Inguinal Hernia

Due to apoplexy

Other condition (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:

(c) 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) Means of injury _____

23. Signature T. E. Brown (M.D. or other) _____

Address R. R. No 1 Date signed _____

PHYSICIAN

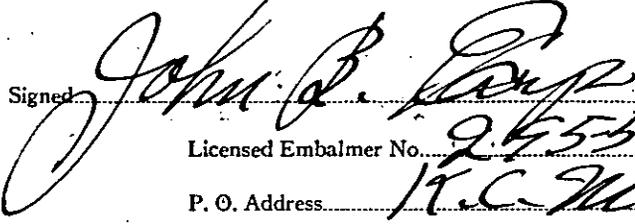
Underline the cause to which death should be charged statistically.

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. 2455

P. O. Address N.C. 710

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.