

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

FILED, JAN 25 1946

Registration District No. 138

Primary Registration District No. 4219

1. PLACE OF DEATH:

(a) County Hickory
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1

(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 60 years

3. (a) PRINT FULL NAME LEONORA C. COALMAN

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife Berky 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov 9 1884
(Month) (Day) (Year)

8. AGE: Years 91 Months 1 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace Randolph Co. Ind
(City, town, or county) (State or foreign country)

10. Usual occupation Home wife

11. Industry or business own home

12. Name Laura Crawford

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

14. Maiden name Mary M. Keel

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

16. (a) Informant John G. Busch

(b) Address W. Campbell MO

17. (a) Burial (b) Date thereof Dec. 30 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pointon Cemetery

18. (a) Signature of funeral director W. H. H. H.

(b) Address Humansville, Mo.

19. (a) Jan 4 '46 (b) W. P. Hargiss
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Hickory
(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? No (Yes or No) _____

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 28
year 1945 hour 2 minute 00 P M.

21. I hereby certify that I attended the deceased from Dec 21
1945, to Dec 28, 1945
that I last saw her alive on Dec 21, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death acute heart failure

Due to chronic myocarditis

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy gnd

Duration

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 Tom Crow (M. D. or other) _____
Address Bolivar Mo Date signed _____

RECEIVED

No. 7,

12-45-1388

1-22-46

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.....

by me

....., Registered Apprentice No.

working under my personal supervision.

Signed *E. H. Rimm*

Licensed Embalmer No. *4282*

P. O. Address *Humansville*

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. Feb
Registrar's No. 17

Registration District No. 138 Primary Registration District No. (5527)

1. PLACE OF DEATH:
(a) County Hickory
(b) City or town Rural Tyler Twp
(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 _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Hickory
(c) City or town Tyler Township
(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 Leonora C. Coalma

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

4. Sex F 5. Color or race w 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 Jan 9
(Month) (Day) (Year)

8. AGE: Years 91 Months _____ Days _____ If less than one day _____ hr. _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

100203 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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