. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 18 1947

Registration District No. 72

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37459

Primary Registration District No. 4289

Registrar's No. 123

1. PLACE OF DEATH:
(a) County: CLARKSON Gallatin Twp.
(b) City or town: RURAL
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: R.R.#1 GRANDVIEW ROAD 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution - - - - - - (Specify whether years, months or days)
In this community: 2 MINUTES

2. USUAL RESIDENCE OF DECEASED:
(a) State: MISSOURI (b) County: CLAY 24
(c) City or town: RURAL - GASHLAND d
(If outside city or town limits, write "RURAL")
(d) Street No.: R.R.#1 - GRANDVIEW ROAD
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country - - - - - -

3. (a) PRINT FULL NAME: Baby Boy COY
3. (b) If veteran, name war: No
3. (c) Social Security No.: NONE

4. Sex: MALE 0
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: SINGLE 0
6. (b) Name of husband or wife: - -
6. (c) Age of husband or wife if alive: - - years
7. Birth date of deceased: OCTOBER (Month) 31 (Day) 1947 (Year)

8. AGE: Years | Months | Days | If less than one day: hr. 2 min.

9. Birthplace: GASHLAND (City, town, or county) MISSOURI (State or foreign country)
10. Usual occupation: INFANT
11. Industry or business: - - - - - -

MOTHER FATHER
12. Name: HOMER L. COY 1
13. Birthplace: ALTOONA (City, town, or county) PENNSYLVANIA (State or foreign country)
14. Maiden name: HELEN LOUISE MADDY
15. Birthplace: KANSAS CITY (City, town, or county) MISSOURI (State or foreign country)

16. (a) Informant: MR. HOMER L. COY
(b) Address: R.R.#1 GRANDVIEW ROAD
17. (a) CREMATION (Burial, cremation, or removal) (b) Date thereof: 11-1-47 (Month) (Day) (Year)
(c) Place: ~~burial or~~ cremation: D.W. NEWCOMER'S SONS
18. (a) Signature of funeral director: D.W. Newcomer Sons
(b) Address: 1401 BRUSH CREEK BLVD.
19. (a) Nov 1st 47 (Date received local registrar) (b) Beulah Kitchen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 31st year 1947 hour 4 minute 05 A.M.
21. I hereby certify that I attended the deceased from 4 AM to 405, 19 47, to, 19; that I last saw him alive on Oct 31, 19 47; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Premature	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: 159
Of autopsy:

PHYSICIAN
Underline the cause of 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: 0
23. Signature: Carl R. Jones (M. D. or other)
Address: Liberty 169 North K.C. Mo Date signed: 10-31-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11-17-47

Head Trinity Lutheran Hosp

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 Bernard L Koran

Licensed Embalmer No. 4250

P. O. Address H C 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.