

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

FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

22439

FILED JUL 27 1948-2

State File No. _____

Registration District No. _____

Primary Registration District No. 5189

Registrar's No. 60

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Advance Rural Welsh 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 25 years (Specify whether _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott / 00

(c) City or town Advance
(If outside city or town limits, write "RURAL")

(d) Street No. R3
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Green Coomer

3. (b) If veteran, _____ name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race white

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Cara Evelyn Coomer

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased Oct. 17, 1858
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>89</u>	<u>8</u>	<u>14</u>	_____ hr. _____ min.

9. Birthplace Adair Co Ky
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name Berry Coomer

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

14. Maiden name Coffee

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

16. (a) Informant Mrs. Wm. Coomer

(b) Address Advance Mo R3

17. (a) Burial (b) Date thereof 7-13-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Perkins, Mo

18. (a) Signature of funeral director Displinghett Funeral Home

(b) Address Chaffee, Mo

19. (a) 7-13-48 (b) D. B. Shuler
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11
year 1948 hour 10 minute 10A: M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h_____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion

Due to Arterio-sclerosis

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? S

While at work? _____ (Specify type of place)

Means of injury Coroner

23. Signature Dr. J. P. Sigmond (M. D. or other) _____

Address Jackson, Mo Date signed 7/11/48

Duration _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

Health Officer No. 4
File Number 748-90
Date Filed 2-24-

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 *Mamie Dupleugh*

Licensed Embalmer No. *3242*

P. O. Address *Chaffee 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.