

FILED DEC 27 1948
Registration District No. 4

Primary Registration District No. 3038

Registrar's No. 103

1. PLACE OF DEATH:

(a) County: Linn

(b) City or town: Brookfield Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Brookfield Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 2 months
(Specify whether)

In this community: 2 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: mo (b) County: Linn 58

(c) City or town: Brookfield 1
(If outside city or town limits, write "RURAL") 3

(d) Street No.: 665 So Main St. 5
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country: _____

3. (a) PRINT FULL NAME: Sarah Rebecca Coons

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

3. (c) Social Security No.: _____

4. Sex: 21 5. Color or race: W 6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: John M Coons 6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased: Oct 3 1960
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

88 2 6 hr. min.

9. Birthplace: Buckingham County W Va
(City, town, or county) (State or foreign country)

10. Usual occupation: at home

11. Industry or business: _____

12. Name: John M Byrd 9

13. Birthplace: York county 9
(City, town, or county) (State or foreign country)

14. Maiden name: Ruhama Roberts

15. Birthplace: Virginia 1
(City, town, or county) (State or foreign country)

16. (a) Informant: John C Byrd

(b) Address: Summer Mo

17. (a) Burial (b) Date thereof: Dec 11 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Brookfield

18. (a) Signature of funeral director: Boudin Funeral Home

(b) Address: Brookfield Mo

19. (a) 12-13-48 (b) Walter Seum
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 9
year 1948 hour 12 minute 07 A.M.

21. I hereby certify that I attended the deceased from: 10/12 1948 to 12/9 1948
that I last saw him alive on: 12/8 1948
and that death occurred on the day and hour stated above.

Immediate cause of death: Chronic Myocarditis Duration (?)

Due to: Fractured hip 10/12/48

Due to: Pelvic Carcinoma (?)

Other conditions: Pt. Femoral Arteriosclerosis 12/4/48
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations: _____

Of autopsy: _____

PHYSICIAN: _____

Underline the cause of which death should be charged to: _____

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) (c) Means of injury: 2

23. Signature: W. C. Green (M. D. or other) 11/10/48
Address: Bucklin, Mo Date signed: 12/10/48

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

MOTHER FATHER

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 JAMES B. McCallard
Licensed Embalmer No. 4230
P. O. Address Brookfield 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.

Registration District No. 184 Primary Registration District No. 3038

1. PLACE OF DEATH:
(a) County Lin
(b) City or town Brookfield
(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 Sarah R. Coon
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

5. Color or race F w
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 48 Months 2 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 _____

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

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

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 _____ year 1948 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ 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 _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external cause, fill in the following:
(a) Accident, suicide, or homicide (specify) trying to walk in new pajama & tripped, falling on hip.
(b) Date of occurrence 10/14/48.
(c) Where did injury occur? BROOKFIELD, LINN, MO. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home, in living room, alone
While at work? _____ (Specify type of place) Means of injury Fallen floor
23. Signature A. G. Sycar (M. D. or other) Dr.
Address Bucklin, Mo. Date signed 1/3/49.

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

SUPPLEMENTARY

S-40698