DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 22 1949

Registration District No. 38

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 152

Primary Registration District No. 3006

Registrar's No. 12

1. PLACE OF DEATH:

(a) County: BOONE

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

(c) Name of hospital or institution: ELLIS FISCHEL STATE CANCER HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1 DAY (Specify whether years, months or days)

In this community: 1 DAY

2. USUAL RESIDENCE OF DECEASED:

(a) State: MISSOURI (b) County: DALLAS

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

(d) Street No.: STAR ROUTE (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: MAHALA CAROLINE FARMER

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~~: W.

6. (b) Name of husband or wife: —

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

7. Birth date of deceased: 6 (Month) — 2 (Day) — 79 (Year)

8. AGE: Years 69 | Months 7 | Days 10 | If less than one day ____ hr. ____ min.

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

10. Usual occupation: HOUSEWIFE

11. Industry or business: ____

MOTHER FATHER

12. Name: JOHN COATNEY

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

14. Maiden name: NANCY COATNEY

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

16. (a) Informant: Mayme Canon

(b) Address: TUNAS, MO.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-16-1949 (Month) (Day) (Year)

(c) Place: burial or cremation: Hopewell Cem.

18. (a) Signature of funeral director: Montgomery-Vaughan

(b) Address: BUFFALO, MO.

19. (a) Jan. 13 1949 (Date received local registrar) (b) Mrs. R. E. Palmer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: JAN day: 12 year: 1949 hour: 8 minute: 30 P.M.

21. I hereby certify that I attended the deceased from JAN 11, 1949, to JAN 12, 1949, that I last saw her alive on JAN 12, 1949, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Perforation of ascending colon	48 hrs
Due to: Large bowel obstruction	10 days
Due to: Inflammatory adhesions, cause undetermined	20 yrs.
Other conditions (Include pregnancy within 3 months of death)	

5705

Major findings:
Of operations: ____
Of autopsy: Confirms above

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? ____ (Specify type of place)

While at work? ____ (e) Means of injury: ____

23. Signature: R. E. Johnson, M.D. (M. D. or other)

Address: Columbia, Mo. Date signed: 1-13-49

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JAN 21 1949

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 Clyde Montgomery

Licensed Embalmer No. J359

P. O. Address Buffalo Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.