

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

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED DEC 29 1949

State File No. 10167

|  |  |  |   |   |   |  |                                  |   |  |
|--|--|--|---|---|---|--|----------------------------------|---|--|
| BIRTH NO.  |  | REG. DIST. NO. 38  |   | PRIMARY REG. DIST. NO. 3006   |   | Registrar's No. 316  |                                  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY Boone   |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE MISSOURI b. COUNTY BOONE  |   |  |                                  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Columbia  |  | c. LENGTH OF STAY (In this place)  |   | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN (ca) COLUMBIA  |   |  |                                  |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: Boone County Hospital   |  |  |   | d. STREET ADDRESS (If rural, give location) 1003 Wilke L) # 1003 WILKES   |   |  |                                  |   |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) JEAN   |  |  | b. (Middle) COAN                            |   |   | 4. DATE OF DEATH (Month) (Day) (Year) Dec, 19, 1949                              |                                  |   |  |
| 5. SEX Female  |  | 6. COLOR OR RACE White   |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married  |   | 8. DATE OF BIRTH DEC 6 1904  |                                  |   |  |
| 9. AGE (In years last birthday) 45   |  | IF UNDER 1 YEAR Months 13  |   | IF UNDER 24 HRS. Hours Min.   |   |  |                                  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE |   | 11. BIRTHPLACE (State or foreign country) MINNESOTA                 |  | 12. CITIZEN OF WHAT COUNTRY? USA |   |  |
| 13a. FATHER'S NAME Don't Know  |  |  | 13b. MOTHER'S MAIDEN NAME Don't Know        |   |   | 14. NAME OF HUSBAND OR WIFE Clarence Coan,                                       |                                  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No   |  | 16. SOCIAL SECURITY NO. 474-16-4409  |   | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Clarence Coan Columbia  |   |  |                                  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. |  |  |   | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Cervix of Uterus with metastasis<br>ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |   |  |                                  | INTERVAL BETWEEN ONSET AND DEATH 10 mo. |  |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.   |  |  |   | 171X  |   |  |                                  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION   |   |   |   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                  |   |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)   |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)   |   |  |                                  |   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)  |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR?  |   |  |                                  |   |  |
| 22. I hereby certify that I attended the deceased from July 20, 1949, to Dec 19, 1949, that I last saw the deceased alive on 12-19, 1949, and that death occurred at 5 PM, from the causes and on the date stated above.     |  |  |   |   |   |  |                                  |   |  |
| 23a. SIGNATURE Roland P. Sedgewick MD (Degree or title)  |  |  |   | 23b. ADDRESS 16 S. 10th Columbia  |   | 23c. DATE SIGNED 12-19-49  |                                  |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL   |  | 24b. DATE DE C. 23-49  |   | 24c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEM.   |   | 24d. LOCATION (City, town, or county) (State) COLUMBIA MO                        |                                  |   |  |
| DATE REC'D BY LOCAL REG. Dec 23 1949   |  | REGISTRAR'S SIGNATURE Mrs. R. E. Palmer 31   |   |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A. Oberholtzer COLUMBIA MO |  |                                  |   |  |

District File Number  
District Health Officer No. 9  
RECEIVED  
DEC 27 1919

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~~ \_\_\_\_\_

\_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student .....  
Student Embalmer

Signed Lynnan H. Sprinkle

Licensed Embalmer No. 4013

P. O. Address Columbia, Mo.

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

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