

FILED MAR 29 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11255

BIRTH NO. _____ REG. DIST. NO. 336 PRIMARY REG. DIST. NO. 4494 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Shannon</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO.</u> b. COUNTY <u>Shannon</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Winona</u>		c. LENGTH OF STAY (in this place) <u>49 yrs</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Winona</u>		1010
d. FULL NAME OF HOSPITAL OR INSTITUTION			d. STREET ADDRESS (If rural, give location) <u>0</u>		

3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u> b. (Middle) <u>(NONE)</u> c. (Last) <u>Coker</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 14-1951</u>		
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5. SEX <u>M</u> <u>0</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 26-1865</u>		9. AGE (In years last birthday) <u>85</u> IF UNDER 1 YEAR Months <u>11</u> Days <u>19</u> IF UNDER 24 HRS. Hours <u>0</u> Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>hail road</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>St. Joseph, MO. 0</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
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13a. FATHER'S NAME <u>John Coker</u>		13b. MOTHER'S MAIDEN NAME <u>Martha nurst</u>		14. NAME OF HUSBAND OR WIFE <u>Laura Coker</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs James Coker, Winona, MO.</u>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Left ventricular Failure</u> ANTECEDENT CAUSES <u>Mitral Stenosis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>410X</u>	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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) <u>Winona Shannon MO.</u>	
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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?	
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22. I hereby certify that I attended the deceased from Mar 15, 1950, to Mar 13, 1951, that I last saw the deceased alive on Mar 13, 1951, and that death occurred at 1:20A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Charles E Sharp MD</u>		23b. ADDRESS <u>Winona MO</u>		23c. DATE SIGNED <u>MAR 19-51</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>mar 18-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New Winona</u>		24d. LOCATION (City, town, or county) (State) <u>winona, Mo.</u>	
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DATE REC'D BY LOCAL REG. <u>3-24-51</u>		REGISTRAR'S SIGNATURE <u>Mabel Pace</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>0 Duncan funeral Home mtn View, Mo</u>	
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

1010

RECEIVED

MAR 27 1951

DISTRICT HEALTH OFFICE No. 6

File No.

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

Joe L. Duncan

Licensed Embalmer No. *4325*

P. O. Address *Mt. View 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.