

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2666**
Registral's No. **0843**

BIRTH NO. **FILED FEB 4 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Howell	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Willow Springs 0460	
c. LENGTH OF STAY (In this place) 4 wks		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hosp.			

3. NAME OF DECEASED (Type or Print)	a. (First) James	b. (Middle) E	c. (Last) Coates	4. DATE OF DEATH (Month) (Day) (Year) 1 24 54
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, / WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Aug 8 1867	9. AGE (In years last birthday) 86	# UNDER 1 YEAR Months	# UNDER 2 YEAR Days	# UNDER 24 Hrs. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	10b. KIND OF BUSINESS OR INDUSTRY Own	11. BIRTHPLACE (City and State or Foreign Country) / Tennessee	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME James	13b. MOTHER'S MAIDEN NAME Unk.	14. NAME OF HUSBAND OR WIFE Sarah
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No	16. SOCIAL SECURITY NO. ?	17. INFORMANT'S SIGNATURE OR NAME Sarah Coates	ADDRESS Willow Springs, Mo.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) A. H. D. - Prostatectomy -		INTERVAL BETWEEN ONSET AND DEATH Year
	ANTECEDENT CAUSES 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.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) 4-20-0
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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 **12-29 1953**, to **1-24 1954**, that I last saw the deceased alive on **1-24 1954**, and that death occurred at **11:00 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE Dr. F. D. [Signature] (Degree or title)	23b. ADDRESS MO. BAPTIST HOSPITAL	23c. DATE SIGNED 1-25-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 1-27-54	24c. NAME OF CEMETERY OR CREMATORY NEW ST. MARCUS	24d. LOCATION (City, town, or county) (State) CITY
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DATE REC'D BY LOCAL REG. JAN 27 1954	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE SCHUMACHER FUNERAL HOME, INC.	ADDRESS 3013 [Address]
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(Licensed Embalmer's Statement on Reverse Side)

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

1971

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 Jack Haupt
Licensed Embalmer No. 4946

P. O. Address Harris 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.