

MED JUL 11 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18262**
Registrar's No. **593**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000**

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Hickory	
b. CITY OR TOWN Springfield,		c. CITY OR TOWN Hermitage	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 1 week		f. STREET ADDRESS (If rural, give location) Central Hermitage	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital			
3. NAME OF DECEASED (Type or Print) Roscoe		a. (First) C.	b. (Middle) Coon
c. (Last) Coon		4. DATE OF DEATH (Month) (Day) (Year) July 5, 1955	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH October 6, 1881
9. AGE (In years last birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banker	11. BIRTHPLACE (City and State or Foreign Country) Hickory County, Missouri
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Banking	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME William F. Coon		13b. MOTHER'S MAIDEN NAME Matilda Lindsey	14. NAME OF HUSBAND OR WIFE Waverly Coon
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 487-10-6070	17. INFORMANT'S SIGNATURE OR NAME Waverly Coon
		ADDRESS Hermitage, Missouri	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Myelogenous leukemia		1 year
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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 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 **11-26**, 19**52** to **7-5**, 19**55**, that I last saw the deceased alive on **7-4**, 19**55**, and that death occurred at **4:00A** m., from the causes and on the date stated above.

23a. SIGNATURE James L. Marshall M.D.	(Degree or title)	23b. ADDRESS Professional Bldg.	23c. DATE SIGNED 7-6-55
24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE July 7, 1955	24c. NAME OF CEMETERY OR REMATORY Hermitage Cemetery	24d. LOCATION (City, town, or county) (State) Hermitage, Missouri
DATE REC'D BY LOCAL REG. 7-6-55	REGISTRAR'S SIGNATURE Edith Williamson	25. FUNERAL DIRECTOR'S SIGNATURE Alma Lohmeyer Jewell E. Windle	
		ADDRESS S.A.S.	

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

JUL 25 1955

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.....
Signature of Student Embalmer

Signed *Robert E. Mallon*.....

Licensed Embalmer No. *491*

P. O. Address *Sprayfield*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.