

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-010629  
STATE FILE NUMBER

FILED-MAR 17 1958

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 95-

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Livingston</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Livingston</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Chillicothe</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Chillicothe 059</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Chillicothe Hospital</b>		Length of stay in lb <b>1 day</b>	d. STREET ADDRESS (If outside, give location) <b>118 Asher St.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>SADIE</b> Middle <b>ELLEN</b> Last <b>COEN</b>			4. DATE OF DEATH Month <b>March</b> Day <b>12</b> Year <b>1958</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 1, '05 53</b>	9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <b>53</b> IF UNDER 24 HRS.: Days <b>53</b> Hours <b>53</b> Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Resturant</b>	11. BIRTHPLACE (City and state or country) <b>Chula Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Joe Burns</b>	13b. MOTHER'S MAIDEN NAME <b>Dora Wilcox</b>	14. NAME OF HUSBAND OR WIFE <b>Lloyd Coen</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>490-10-3182</b>	17. INFORMANT <b>Lloyd Coen 118 Asher; Chillicothe Mo</b> Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertensive vascular disease</b>		
DUE TO (c) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>331X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>2</b>
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
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21. I attended the deceased from <u>3/11/58</u> to <u>3/12/58</u> and last saw her alive on <u>3/12/58</u> Death occurred at <u>Seven Fifteen</u> Am on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>William F. Farr, M.D.</b> (Registrar title)	22b. ADDRESS <b>Chillicothe, Mo</b>	22c. DATE SIGNED <b>3/12/58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Mar. 14, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>May Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Chula Livingston Mo.</b>
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24. FUNERAL DIRECTOR <b>Norman Funeral Home Chillicothe</b> ADDRESS	25. DATE RECD. BY LOCAL REG. <b>3-12-58</b>	26. REGISTRAR'S SIGNATURE <b>Frances B Neill</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Color, Coroner, etc. must use only standard nomenclature. All diseases in Part I must be causally related.

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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 *Elton J. Norman* .....

Licensed Embalmer No...4036.....  
P. O. Address Chillicothe, M.....

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.