

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004518

STATE FILE NUMBER

FILLED FEB 24 1959

Registration District No. 38

Primary Registration District No. 5120

Registrar's No. 83

300
1-57 4

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Boone | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Boone | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN Columbia 01050 |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Boone Co. Rest Home | | Length of stay in 1b Lifetime | d. STREET ADDRESS (If outside, give location) 1310 Bass Ave. |
| Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |

| | | | | | |
|---|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last REBECCA GRANT COONS | | | 4. DATE OF DEATH Month Day Year February 16, 1959 | | |
|---|--|--|---|--|--|

| | | | | | | | | | |
|------------------|---------------------------|---|---------------------------------|------------------------------------|--|---|--|--------------------------------|--|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 4, 1869 | 9. AGE (In years last birthday) 89 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. | |
|------------------|---------------------------|---|---------------------------------|------------------------------------|--|---|--|--------------------------------|--|

| | | | | | |
|--|--|--|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (City and state or country) Boone County, Missouri | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
|--|--|--|--|--|--|

| | | | | | |
|--|--|---|--|---|--|
| 13a. FATHER'S NAME Milton Stevinson | | 13b. MOTHER'S MAIDEN NAME Edith Bruton | | 14. NAME OF HUSBAND OR WIFE W.W. Coons | |
|--|--|---|--|---|--|

| | | | | | |
|---|--|---------------------------------|--|--|--|
| 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. None | 17. INFORMANT Mrs. Ralph Berkley, Hallsville, Mo. | | |
|---|--|---------------------------------|--|--|--|

| | | | | | |
|--|--|--|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Valvular Heart Disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4214</u> | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

| | | | | | |
|---|--|---|--|--|--|
| 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.) - | | | |
|---|--|---|--|--|--|

| | | | | | |
|---|--|---|--|--|--|
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | 20d. INJURY OCCURRED WHILE AT <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 Columbia | | COUNTY Boone | STATE Missouri |
|---|--|--|--|-----------------|-------------------|

21. I attended the deceased from May - 1956 to Feb - 1959 and last saw ^{her} _{him} alive on Feb - 13 - 59
Death occurred at 7:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.

| | | | | |
|--|--|------------------------------------|--|------------------------------------|
| 22a. SIGNATURE <u>F.C. Duggett M.D.</u> (Degree or title) | | 22b. ADDRESS <u>Columbia Mo</u> | | 22c. DATE SIGNED <u>2-17-59</u> |
|--|--|------------------------------------|--|------------------------------------|

| | | | | | | |
|---|--|----------------------------|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Feb. 18, 1959 | 23c. NAME OF CEMETERY OR CREMATORY Red Top Cemetery | | 23d. LOCATION (City, town, or county) (State) Boone County, Missouri | |
|---|--|----------------------------|--|--|---|--|

| | | | | | |
|---|--|---------|---|---|--|
| 24. FUNERAL DIRECTOR Parker Funeral Service, Columbia, Mo. | | ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>Feb. 18 1959</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs RE Palmer</u> | |
|---|--|---------|---|---|--|

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be stated. All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

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 *J. W. Phillips*
Licensed Embalmer No. *4897*
P. O. Address *Columbia, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.