

59-020859

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Health,
& Welfare
Public
Service

FILED JUL 8 1959

Registration District No. 107

Primary Registration District No. 2019

Registrar's No. 112

S. 300
1-57

| | | | | | |
|---|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Dunklin</i> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>New Madrid</i> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kennett</i> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <i>Gideon</i> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Memorial Hosp.</i> | | Length of stay in lb <i>6 hrs.</i> | d. STREET ADDRESS (If outside, give location) <i>072</i> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>WILLIAM Jesse Coons</i> | | | 4. DATE OF DEATH Month Day Year <i>6-17-1959</i> | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>11-22-1879</i> | | 9. AGE (In years less (if day) Months Days Hours Min.) <i>81</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Law enforcement</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>none</i> | 11. BIRTHPLACE (City and state or country) <i>Malden, Mo.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |
| 13a. FATHER'S NAME <i>Wm. Coons</i> | | 13b. MOTHER'S MAIDEN NAME <i>Nancy Jane Henson</i> | | 14. NAME OF HUSBAND OR WIFE <i>Archie Coons</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>500-10-9978</i> | 17. INFORMANT Address <i>Archie Coons Gideon Mo</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Prostate</i> | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 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) | | | | | 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 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 | |
| 21. I attended the deceased from <i>June 17, 1955</i> to <i>June 17, 1959</i> and last saw ^{her} him alive on <i>June 17, 1959</i> Death occurred at <i>7:15 P. M.</i> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Deceased or title) <i>George W. Russell M.D.</i> | | | 22b. ADDRESS <i>Kennett Mo</i> | | 22c. DATE SIGNED <i>6/28/59</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <i>6-21-1959</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Malden Park Cem.</i> | |
| | | | | 23d. LOCATION (City, town, or county) (State) <i>Malden, Mo.</i> | |
| 24. FUNERAL DIRECTOR'S ADDRESS <i>Floyd Russell 101 Ark 6:30-59 East Luskand</i> | | | 25. DATE RECD. BY LOCAL REG. <i>6:30-59</i> | | 26. REGISTRAR'S SIGNATURE <i>East Luskand</i> |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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

Geo. Furness

COUNTY FILE NUMBER 759-192

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 *Lloyd Russell*

Licensed Embalmer No. *509-94*
P. O. Address *Piggott, Ark*

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.