

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-025635

FILED VS. AUG 9 1960

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 234

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Adair				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Cole				
b. CITY (If outside corporate limits, give TOWNSHIP only) Kirksville		Length of stay in 1b 1 day		c. CITY OR TOWN Jefferson City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 214 S. High St.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 307 Boonville Rd.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle LYCURGUS Last COON, Sr.				4. DATE OF DEATH Month August Day 1 Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> UNMARRIED WIDOWED XXXXXXXXXXXX	8. DATE OF BIRTH 3/30/05	9. AGE (last birthday) 55	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR. Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent, Salesman			10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (City and state or country) Hermitage, Mo.		12. CITIZEN OF WHAT COUNTRY U S	
13a. FATHER'S NAME Bernie Coon			13b. MOTHER'S MAIDEN NAME Myrtle E. Sanders			14. NAME OF HUSBAND OR WIFE Lucille Roland		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. 163-10-8949		17. INFORMANT Address Lucille Coon, Jefferson City, 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) Coronary occlusion							INTERVAL BETWEEN ONSET AND DEATH 3-5 min.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) cardiac disease (unknown)						
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N- <input type="checkbox"/> Unknown		
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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Month, Day, Year						
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 on 8-1-60 and last saw ^{her} him alive on DOA . Death occurred at 11:15a on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>W. Maddox</i>			(Degree or title) DO			22b. ADDRESS Kirksville (mo) Osteopathic Hosp	22c. DATE SIGNED 8-1-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/4/60	23c. NAME OF CEMETERY OR CREMATOR Riverview		23d. LOCATION (City, town, or county) (State) Jefferson City, Cole, Mo.			
24. FUNERAL DIRECTOR <i>Novis Foster</i>			ADDRESS Foster Memorial Home, Kirksville, Mo.		25. DATE RECD. BY LOCAL REG. 8-1-1960	26. REGISTRAR'S SIGNATURE <i>Doris W. Ratliff</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS SEP 8 - 1960

D. E. Maddox, D. O.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Nova E. Foster
Nova E. Foster

Licensed Embalmer No. ~~XXXX~~ 471

P. O. Address Kirkville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.