

**FEDERAL BUREAU OF INVESTIGATION - HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS NOV 15 1960

**-60-040772**

STATE FILE NUMBER

Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 97

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Milan</u>		Length of stay in 1b <u>2 hrs.</u>		c. CITY OR TOWN <u>Jackson Twp</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Sull. Co. M. Hospit</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>Francis Faye Coon</u>				4. DATE OF DEATH Month Day Year <u>11-10-1960</u>									
5. SEX <u>F m</u>		6. COLOR OR RACE <u>w</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>4-5-1904</u>		9. AGE (last birthday) <u>56</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Milan - Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>					
13a. FATHER'S NAME <u>Daniel Shatto</u>				13b. MOTHER'S MAIDEN NAME <u>Minnie Smith</u>				14. NAME OF HUSBAND OR WIFE <u>W. T. Coon</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>W. T. Coon Milan - Mo</u>							
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>hemorrhage &amp; Brain compression</u> DUE TO (b) <u>-</u> DUE TO (c) <u>shot wound in back head</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs -</u> <u>2 hrs -</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>self-inflicted rifle wound</u>									
20c. TIME OF INJURY Hour <u>6:30</u> a.m. Month, Day, Year <u>11-10-60</u>		depressed from suffering c. 9.											
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. CITY, TOWN, OR LOCATION <u>Milan</u>		COUNTY <u>Sullivan</u>		STATE <u>Mo</u>					
21. I attended the deceased from <u>8:30 am</u> to <u>-</u> and last saw her alive on <u>11-10-60</u> Death occurred at <u>8:30 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>E. Simpson D.O.</u>						22b. ADDRESS <u>Milan, Mo</u>			22c. DATE SIGNED <u>11-12-60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-16-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Judson Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Jackson Twp Sull. Mo.</u>							
24. FUNERAL DIRECTOR <u>Schoenes</u> <u>Sueht Schoenes</u>				ADDRESS <u>Milan - Mo</u>		25. DATE RECD. BY LOCAL REG. <u>11-13-60</u>		26. REGISTRAR'S SIGNATURE <u>Max M...</u>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by r

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Dwight Schoene

Licensed Embalmer No. 2667

P. O. Address Mulan - 1

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