

Dr. Walterscheid
MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-007192

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 71
FILED MAR 7 1962

1. PLACE OF DEATH a. COUNTY Marion			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Marion		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal		Length of stay in 1b	c. CITY OR TOWN Hannibal		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Elizabeth Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 413 Grand Ave.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle Vernon Last Coates			4. DATE OF DEATH Month Feb. Day 9 Year 1962		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1879	9. AGE (last birthday) 82	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-Retired		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Marble Creek, Mo.	12. CITIZEN OF WHAT COUNTRY U.S. A.	
13a. FATHER'S NAME Peter Coates		13b. MOTHER'S MAIDEN NAME Nancy Snyder		14. NAME OF HUSBAND OR WIFE Flora A. Coates	
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.		17. INFORMANT Mrs. Flora Coates, 413 Grand Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure DUE TO (b) Acute urinary retention DUE TO (c) Prostatic hypertrophy Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			Hannibal, Mo.		INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 1 month
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"/> No <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 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 <u>2/6/62</u> to <u>2/9/62</u> and last saw him ^{not} alive on <u>2/9/62</u> Death occurred at <u>3:45 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>J. H. Walterscheid M.D.</i>		22b. ADDRESS <i>Hannibal Mo.</i>		22c. DATE SIGNED 2/16/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb. 10, 1962	23c. NAME OF CEMETERY OR CREMATORY Grand View Burial Park	23d. LOCATION (City, town, or county) (State) Hannibal, Mo.		
24. FUNERAL DIRECTOR H.M.O'Donnell, Hannibal, Mo.		25. DATE RECD. BY LOCAL REG. Feb. 23, 1962	26. REGISTRAR'S SIGNATURE <i>Dr. E. M. Kuska by Lillian M. Herman</i>		

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

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. M. O'Connell*

Licensed Embalmer No. 3889

P. O. Address Hannibal, 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.