

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-035450**

STATE FILE NUMBER

Registration District No. 72 Primary Registration District No. 4134 Registrar's No. 208

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1 6000

2 5110

3

4 0

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9 2044

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11

12 92-0

13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

<b>FILED SEP 19 1963</b>		1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Smithville</u>		Length of stay in 1b <u>D.O.A.</u>		c. CITY OR TOWN <u>Agency</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Smithville Community Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3 mi. South of Frazier Mo-Hwy E.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bernie</u> Middle <u>Hill</u> Last <u>Coons</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>12</u> Year <u>1963</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>Sept. 27, 1915</u>	9. AGE (last birthday) <u>47</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (City and state or country) <u>Paradise Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Floyd Coons</u>		13b. MOTHER'S MAIDEN NAME <u>Alice Madine Young</u>		14. NAME OF HUSBAND OR WIFE <u>Alice H. Coons</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WWII</u>		16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT <u>Alice H. Coons - Agency, Mo.</u> Address _____	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stem Cell Leukemia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</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)				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 _____ a.m. _____ p.m. Month, Day, Year _____					
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.)	20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>Aug 1969</u> to <u>Sept 12, 1963</u> and last saw <sup>has</sup> him alive on <u>Sept 12, 1963</u> Death occurred at <u>750 p</u> on the date stated above, and to the best of my knowledge, from the causes stated:					
22a. SIGNATURE (Degree or title) <u>David R. Coons MD</u>		22b. ADDRESS <u>Smithville, Mo</u>		22c. DATE SIGNED <u>9-14-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 15, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Platte City Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Platte City Mo.</u>	
24. FUNERAL DIRECTOR <u>Clarence E. Hixson - Gower Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-15-63</u>		26. REGISTRAR'S SIGNATURE <u>Marquette Hudgens</u>	

(Licensed Embalmer's Statement on Reverse Side)

SEP 25 1963

OCT 29 1963

**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 Clarence E. Hipson

Licensed Embalmer No. 5122

P. O. Address Lowell, 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.