

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-042702
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 381

FILED DEC 2 1963

VS 300
Rev. 4/59

1 0019
2 0611
3
4 1
5 1
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7 0
8 1
9 0611
10
11
12 2-2
13 1-0

DATE AMENDED 12/10/63

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO. 16 P. 11

Puncture wound of foot cause unknown

Wound found at autopsy, family unaware of presence

DOCUMENT

BY AFFIDAVIT OF attending physician

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Macon</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>TOWN Kirksville, Mo.</u>			Length of stay in 1b <u>2 days</u>		c. CITY OR TOWN <u>Macon, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>K.O.H.</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>814 Vine Street</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>BETTY</u> Last <u>COCNS</u>				4. DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>1963</u>			
5. SEX <u>female</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>2/23/1927</u>	9. AGE (last birthday) <u>36</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Macon, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Floyd Skinner</u>			13b. MOTHER'S MAIDEN NAME <u>Adeline Jones</u>		14. NAME OF HUSBAND OR WIFE <u>Floyd Coons Jr.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Toxemia</u>							<u>20 hours</u>
DUE TO (b) <u>Titanium</u>							<u>38 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Puncture wound of foot cause unknown</u>					
20c. TIME OF INJURY Hour <u> </u> Month, Day, Year a.m. <u> </u> p.m. <u> </u>	<u>Wound found at autopsy-- family unaware of presence</u>						
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>Nov 25, 1963</u> to <u>Nov 26, 1963</u> and last saw her alive on <u>Nov 26, 1963</u> Death occurred at <u>4 45</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>M.D. Lutenashner D.O.</u>				22b. ADDRESS <u>Ferksville Mo</u>		22c. DATE SIGNED <u>11-26-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1963 Nov. 29</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Richardsdale Cemetery</u>		23d. LOCATION (City, town, or county) <u>Berier, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Lester Hutton</u>			ADDRESS <u>Macon, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-27-63</u>	26. REGISTRAR'S SIGNATURE <u>Dore W. Ratliff</u>	

USE BLACK INK
OR
TYPEWRITER RIBBON

DEC 4 1963

M. T. GUTENSON, D.O.

Permit issued Nov 27, 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 Robert B. Davis

Licensed Embalmer No. 4219

P. O. Address Kirkville, 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.