

FILED MAR 6 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

5476

Registration District No. 200

Primary Registration District No. 3041

Registrar's No. 17

## 1. PLACE OF DEATH

a. COUNTY

MACON

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Missouri

b. COUNTY

MACON

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR  
TOWN

MACON

Inside Limits  
Yes ☒ No ☐c. CITY  
OR  
TOWN

ATLANTA

0610  
0Inside Limits  
Yes ☒ No ☐c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR  
INSTITUTION

SAMARITAN

Length of stay in 1b  
4 daysd. STREET  
ADDRESS

(If outside, give location)

Reside on Farm  
Yes ☐ No ☒3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

MYRTLE

MAY

COOGAN

4. DATE  
OF  
DEATH

Month

Day

Year

2-18-1957

## 5. SEX

Female

## 6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

## 8. DATE OF BIRTH

4-6-1890

9. AGE (In years  
last birthday)

66

IF UNDER 1 YEAR IF UNDER 24 HRS.  
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

House wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

ATLANTA, Mo

12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME

THOMAS DOWNEY

## 14. MOTHER'S MAIDEN NAME

MARY E. HADLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(If yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

489-26-7765

## 17. INFORMANT

FRANK COOGAN

## Address

ATLANTA, 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)

Cerebral Hemorrhage

INTERVAL BETWEEN  
ONSET AND DEATH  
4 daysConditions, if any,  
which gave rise to  
above cause (a),  
stating the under-  
lying cause last.

## DUE TO (b)

Hypertension - Myocarditis

See 12a

## DUE TO (c)

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?  
YES ☐ NO ☒

MEDICAL CERTIFICATION

## 20a. ACCIDENT

☐

## SUICIDE

☐

## HOMICIDE

☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

443X

2

20c. TIME OF  
INJURYHour Month, Day, Year  
a. m. p. m.

## 20d. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK☐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 5/27/49 to 2/18/57 and last saw her alive on 2-17-57  
Death occurred at m on the date stated above; and to the best of my knowledge, from the causes stated.

## 22a. SIGNATURE

(Degree or title)

## 22b. ADDRESS

## 22c. DATE SIGNED

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

## 23b. DATE

## 23c. NAME OF CEMETERY OR CREMATORY

## 23d. LOCATION (City, town, or county)

(State)

## 24. FUNERAL DIRECTOR

## ADDRESS

## 25. DATE RECD. BY LOCAL REG.

## 26. REGISTRAR'S SIGNATURE

Theo H. Goodding-ATLANTA, MO

2/22/57

Curt M. Neely.

(Licensed Embalmer's Statement on Reverse Side)

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Ceremy P. H. N. 201  
Date Filed 2.27.57

DEC 18 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em  
by me, ~~or by~~ *Thos H Goodding*....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Thos H Goodding*  
Licensed Embalmer No. 39.

P. O. Address *Atlanta*..

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