

FILED JUN 15 1948

Registrar's No. 30

Registration District No. 77

Primary Registration District No. 4171

1. PLACE OF DEATH:

(a) County De Kalb  
(b) City or town Clarksdale  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 60 Years  
years, months or days

3. (a) PRINT FULL NAME Robert Lee Coffey

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Molley Coffey 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased Sept, 20  
(Month) (Day) (Year) 1865

8. AGE: Years 82 Months 4 Days 24  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Harrey Coffey

13. Birthplace Kent  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Kent  
(City, town, or county) (State or foreign country)

16. (a) Informant Molley Coffey

(b) Address Clarksdale Mo. 4-17-48

17. (a) Burial (b) Date thereof 4-17-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clarksdale Mo

18. (a) Signature of funeral director John Brown

(b) Address Mayaville Mo

19. (a) 5-8-48 (b) Davidson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County De Kalb  
(c) City or town Clarksdale Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14  
year 1948 hour 2 minute 00 P. M.

21. I hereby certify that I attended the deceased from April 6 1948 to April 14 1948  
and that death occurred on the date and hour stated above.  
that I last saw him alive on April 13 1948

Immediate cause of death \_\_\_\_\_  
Cerebral Hemorrhage  
Due to Hypertension  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
(Specify type of place) \_\_\_\_\_  
(c) Means of injury \_\_\_\_\_  
While at work \_\_\_\_\_

23. Signature Dr. O. R. Van Dine (M. D. or other) \_\_\_\_\_  
Address 823 Faraon Memphis Mo signed 4-26-48

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

32  
0  
0  
0

Duration

7 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

dist. of

DEPT. OF  
HEALTH

ON

FORM

NO. 100

Robert Lee Coffey

DISTRICT HEALTH OFFICER  
Cameron, Mo.

DATE

OFFICE

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

Registered Apprentice No.

working under my personal supervision.

Signed

*John P. Brown*  
Licensed Embalmer No. 3933

P.O. Address

*Clayton, 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 this body is not embalmed, fact should be so stated above.