

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

9046

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township New Precinct Registration District No. 100
 City Kansas City (No. Quintette) Frank St. _____ Ward _____

File No. _____
 Registered No. 1222
 St. _____ Ward _____

2. FULL NAME

Dan Coffman
 (a) Residence No. 2508 E Frank St. _____ Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. _____ ds. How long in U.S., if of foreign birth? yrs. mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Nellie Ellen Coffman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 25 - 1887

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
40 3 23

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work laborer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Unknown

14. INFORMANT Nellie E. Coffman (Address) 110 Garland

15. FILED 3/19 E. M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 18 1928 Sunday

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____, 19____, at _____, 19____, m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hemiplegia cerebrale
173/9M

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____ WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DISEASE? _____ (Signed) Henry C. Garbraugh, M. D. 3/19, 1928 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forest Hill DATE OF BURIAL March 21 1928

20. UNDERTAKER Clyde Funeral Home ADDRESS 1800 Linwood

WRITE FULLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

