

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

3270

JAN 28 1929

1. PLACE OF DEATH  
 County Ste Genevieve Registration District No. 783  
 Township Sulines Primary Registration District No. 6029  
 City \_\_\_\_\_ (Name) \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Douglas Coffman  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 7 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da. How long in U.S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 Frank Coffman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 11 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
79      4      24

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 27 1928  
 I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_ that I last saw him alive on \_\_\_\_\_ 1929, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Heart Disease  
Chronic Bronchitis  
3 days corditis  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

CONTRIBUTORY (SECONDARY) 90B  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

9. BIRTHPLACE (CITY OR TOWN) Ste Genevieve Co.  
 (STATE OR COUNTRY)

10. NAME OF FATHER Thos Bryan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Dont know  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Dont know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Dont know  
 (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH, \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Chisical  
 (Signed) P. Appleberry, M. D.  
Jan 5, 1929 (Address) Harrington, Missouri

14. INFORMANT Dott Coffman  
 (Address) Ritesville mo.

15. FILED 76 29 1929 C. A. Boyd Reg.  
 REGISTRAR

\*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Park View cemetery DATE OF BURIAL Jan 6 19 29

20. UNDERTAKER Farrington Co. Farrington Mo ADDRESS \_\_\_\_\_

95  
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23  
31  
31

on should be carefully supplied. Age should be stated in full terms, so that it may be properly classified. Exact statement of OCCURANCE/CAUSE/is very important.

# Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

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

1-29  
ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH  
 County St. Genevieve Registration District No. 783 File No. ....  
 Township Valerie Primary Registration District No. 6029 Registered No. ....  
 City (No. ....) St. .... Ward) .....

2. FULL NAME Douglas Coffman  
 (a) Residence No. .... St. .... Ward. .... (If nonresident give city or town and State)  
 (Usual place of abode) .....

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

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frank E. Coffman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 11 1849

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>79</u>	<u>11</u>	<u>24</u>	

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

9. BIRTHPLACE (CITY OR TOWN) St. Genevieve, Mo.  
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Thomas Bryan

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Rolla Coffman  
 (Address) .....

15. FILED 1/6 1929 C. A. Boyd REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 5th 1929

17. I HEREBY CERTIFY That I attended deceased from Dec. 27 1928 to Jan. 3 1929 that I last saw her alive on Jan. 3 1929, and that death occurred, on the date stated above, at 5:45 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

arterio-sclerosis of the  
coronary arteries  
causing  
myocardial infarction  
 (duration) .... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH: same  
 DID AN OPERATION PRECEDE DEATH: no DATE OF .....

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH: same  
 DID AN OPERATION PRECEDE DEATH: no DATE OF .....

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Park View Cem. DATE OF BURIAL Jan. 6 1929  
 ADDRESS Hamington, Mo.

\*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 Park View Cem. DATE OF BURIAL Jan. 6 1929  
 ADDRESS Hamington, Mo.

20. UNDERTAKER Hamington Ind. Co  
 ADDRESS Hamington, Mo.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

AGE should be given exactly. PHYSICIAN should be given exactly. Exact statement of OCCUPATION is required. STATE should be given exactly. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

