23 1929

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

Do not use this space.

9497

1. PLACE OF DEATH
County Bates
Township Rockville
City Rockville
Registration District No. 54
Primary Registration District No. 4032
File No.
Registered No.
(No. ..... St. ..... Ward)

2. FULL NAME Lucinda Coffer
(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 51 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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 John D. Coffer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 20, 1841

7. AGE: 87 YEARS | MONTHS: 10 | DAYS: 15 | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) Chicago
(STATE OR COUNTRY) Illinois

PARENTS
10. NAME OF FATHER James Robertson
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Virginia
12. MAIDEN NAME OF MOTHER Cathrine Welch
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Ireland

14. INFORMANT John D. Coffer
(Address) Rockville Mo

15. FILED Mch 8 1929 Mrs. A. B. Freeman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 7 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 28, 1929, to Mar 7, 1929, that I last saw her alive on Mar 7, 1929, and that death occurred, on the date stated above, at 2:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Organic Heart Disease
(Valvular insufficiency)
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Senility
(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? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) A. B. Freeman, M. D
, 19 (Address) Rockville, 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: Robbins Kenney
DATE OF BURIAL: Mch 9 1929

20. UNDERTAKER: Robert Kenney
ADDRESS: Appleton City

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

#6 added by supp.

235

2

2

15

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County: Bates — Registration District No.: 54 — File No.: 9491
Township: — Primary Registration District No.: 4032 — Registered No.:
City: Rockville (No. ..., ... St. ..... Ward)

2. FULL NAME Lucinda Coffee

(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 ... yrs. ... mos. ... ds. How long in U.S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 20 1841

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.
	87	10	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(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)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED Mar 8, 1929 Max A. B. Foreman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 7 1929

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 ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
..... (duration) ... yrs. ... mos. ... ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important

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

S-9497