

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

Do not use this space.

29064

**1. PLACE OF DEATH**

County \_\_\_\_\_  
Township \_\_\_\_\_  
City \_\_\_\_\_ No. \_\_\_\_\_

Registration District No. 791  
Primary Registration District No. 1003  
3909 Kennedy

File No. \_\_\_\_\_  
Registered No. 8187  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence No. 3909 Kennedy Ave, 11 Ward.

(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 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 Hellie Coff

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 26 - 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
68 11 12

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

9. BIRTHPLACE (CITY OR TOWN) St. Louis  
(STATE OR COUNTRY) Mo

10. NAME OF FATHER James Coff

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

12. MAIDEN NAME OF MOTHER Helen Hocks

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known  
(STATE OR COUNTRY)

14. INFORMANT Mrs. Hellie Coff  
(Address) 3909 Kennedy Ave

15. FILED \_\_\_\_\_ 19 \_\_\_\_\_ REGISTRAR Wm C. Strang

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 8 1939

17. I HEREBY CERTIFY, That I attended deceased from Jan. 2 1928 to Aug. 8 1939 that I last saw him alive on Aug 30 1939 and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

1 Stroke  
Hemiplegia apoplectic  
(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (SECONDARY) Chronic nephritis  
(duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 12900  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

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

WAS THERE AN AUTOPSY? no

WHICH TEST CONFIRMED DIAGNOSIS? Physical ex  
(Signed) W.A. Johnson, M. D.  
1/9, 1929 (Address) 2435 N Grand

\*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 Calvary Cemetery DATE OF BURIAL Aug 10 1939

20. UNDERTAKER Wm. L. Pella 2707 N. Grand ADDRESS

WHATEVER PRINT, 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.

