

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

Do not use this space.

35502

1. PLACE OF DEATH

County Wright
Township Van Buren
City (No.)

Registration District No. 906
Primary Registration District No. 6219

File No.
Registered No. 49
St. Ward

2. FULL NAME

Alta Elizabeth 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 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Dependent Child

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 4/1931

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,	
				hrs.	min.
<u>2</u>	<u>4</u>	<u>23</u>	<u> </u>	<u> </u>	<u> </u>

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Child

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Hartsville, Mo. (STATE OR COUNTRY) Wright Co.

13. NAME John Coffman

14. BIRTHPLACE (CITY OR TOWN) Missouri (STATE OR COUNTRY) Wright Co.

15. MAIDEN NAME May Ellis

16. BIRTHPLACE (CITY OR TOWN) Missouri (STATE OR COUNTRY) Wright Co.

17. INFORMANT John Ellis (ADDRESS) Ray, Mo.

18. BURIAL, CREMATION, OR REMOVAL Green Mountain DATE 28, 1933

19. UNDERTAKER None (ADDRESS)

20. FILED May 28, 1933 Carolyn White Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 27 Oct, 1933

22. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 .

I last saw h. alive on , 19 . Death is said to have occurred on the date stated above, at 5.9 m.

The principal cause of death and related causes of importance were as follows:

Dementia Tremor
and
and
Child was dead 3
or 4 hours Dr. Budge
Other contributory causes of importance:
Went away cut neck
certified
115A

Name of operation 115A Date of
What test confirmed diagnosis? Was there an autopsy?

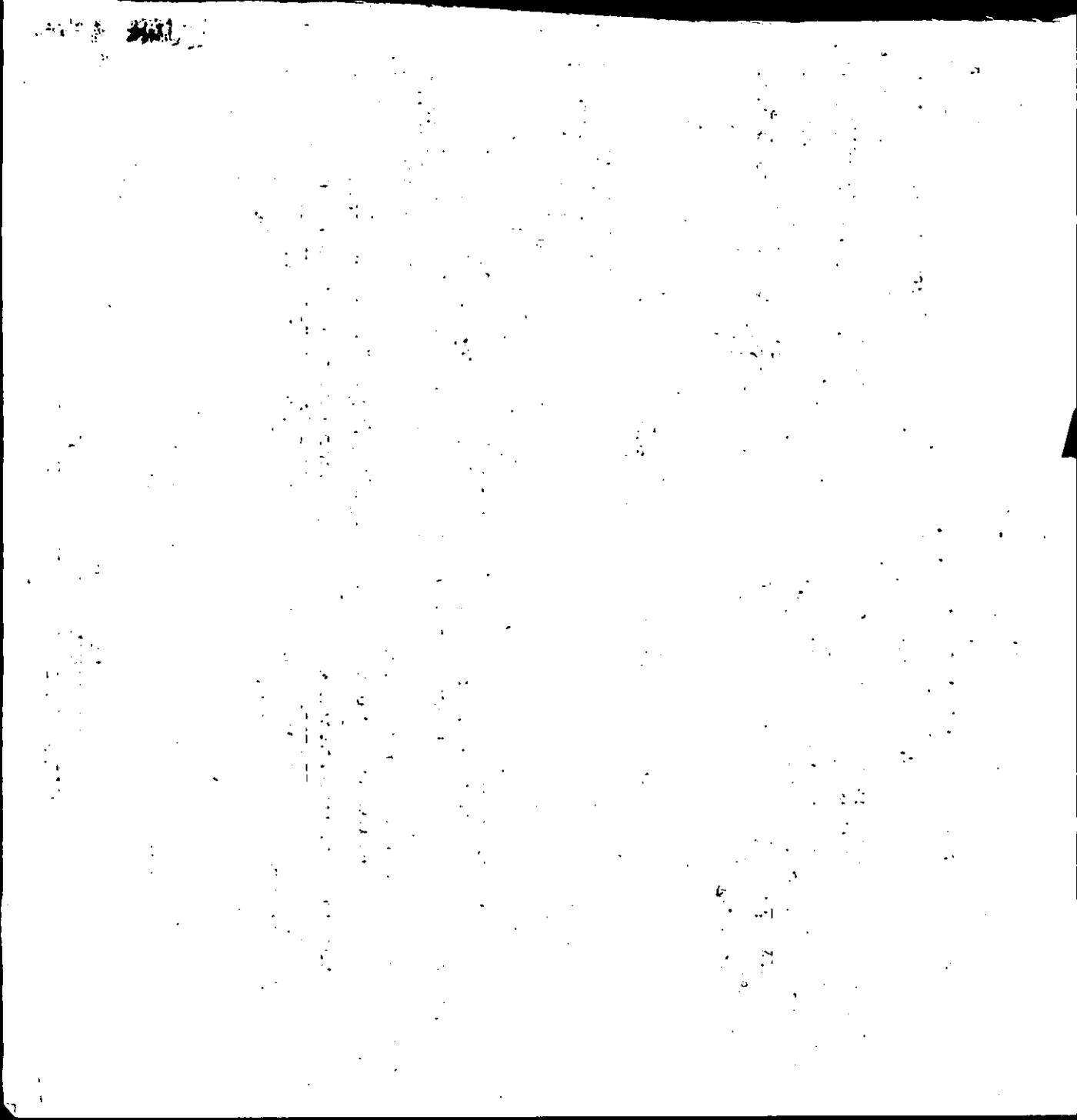
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide Date of injury , 19

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) John Coffman, Father M. D.
(Address) Ray, Mo.



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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Wright Registration District No. 906
Township Joiner Primary Registration District No. 6219
City Wright (No. _____) St. _____ Ward _____

File No. 35502
Registered No. 49

2. FULL NAME

Alta Elizabeth 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 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) _____

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____

19. UNDERTAKER (ADDRESS) _____

20. FILED _____ 19 Carlyne White Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 27 19 33

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19 _____

I last saw him _____ alive on _____, 19 _____ Death is said

to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

I never saw this child either dead or alive. I was called to see some other children in the same neighborhood after this child died. They had bad cases of gonorrhoea and this child was supposed to have a throat infection.

Name of operation _____ Date _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) J. T. Bridges, M.D.
(Address) Marion, Mo.

SUPPLEMENTARY

CERTIFICATE UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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