

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.

114
JUL 12 1934

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

Do not use this space.

1. PLACE OF DEATH
 County Washington Registration District No. 907 File No. 22995
 Township Pleasant Valley Primary Registration District No. 6220 Registered No. 22
 City (No.) St. Ward

2. FULL NAME Ella Coffman
 (a) Residence, No. St. Ward.
 (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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>widowed</u>
6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Widowed</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec 25 - 1858</u>		
7. AGE YEARS <u>76</u>	MONTHS <u>5</u>	DAYS <u>28</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>house wife</u>		
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) <u>Missouri</u>		
13. NAME <u>Coffman</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>		
15. MAIDEN NAME <u>Hart</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>		
17. INFORMANT (ADDRESS) <u>Dolly Houston</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Climax Spring</u> DATE <u>June - 22</u> 19 <u>34</u>		
19. UNDERTAKER (ADDRESS) <u>R. K. Kelley</u>		
20. FILED <u>June 7, 1934</u> <u>Amos C. Roy</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June - 21 1934

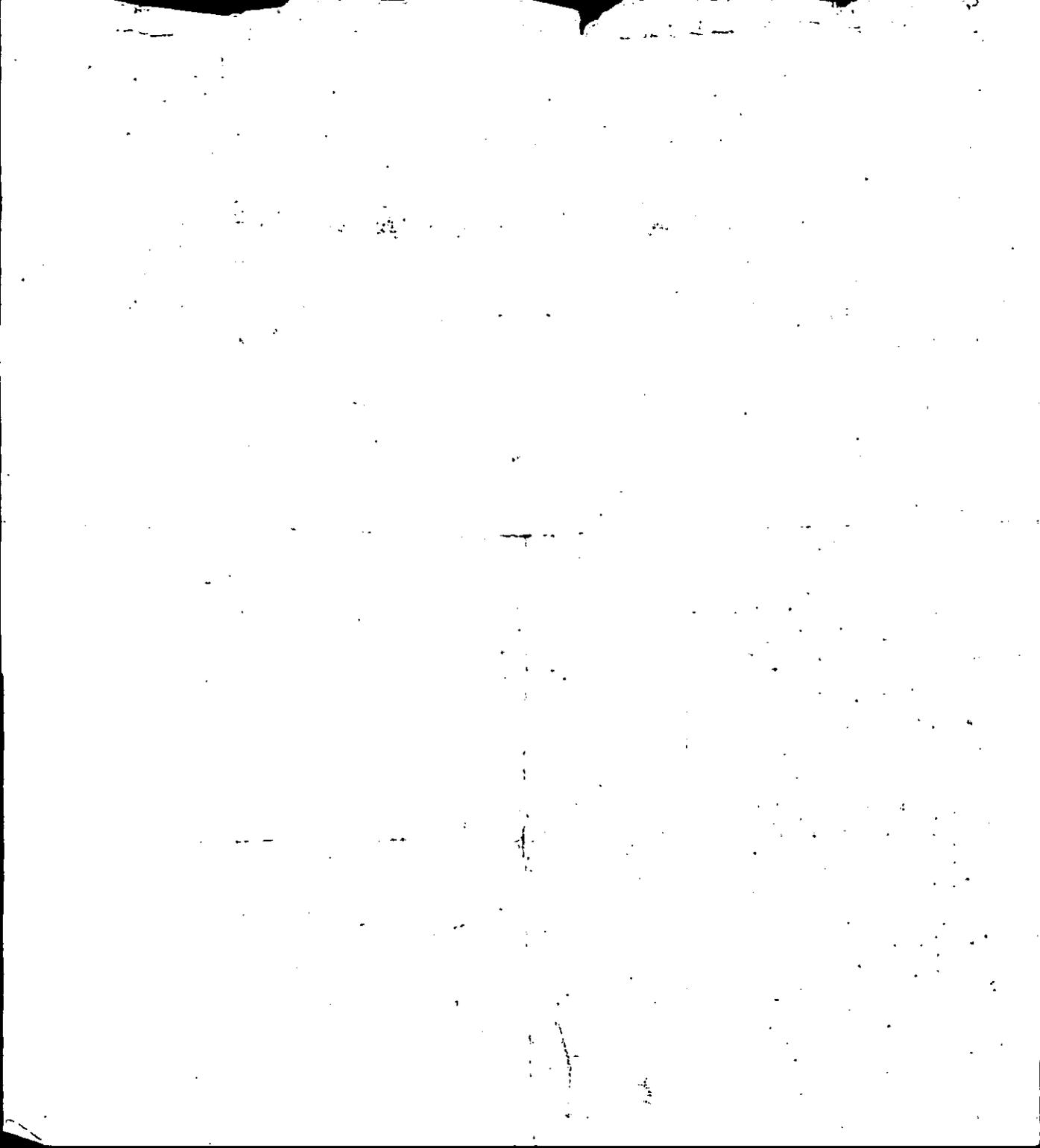
22. I HEREBY CERTIFY, That I attended deceased from June 17 1934, to June - 19 1934
 I last saw h. alive on June 19 19. Death is said to have occurred on the date stated above, at 1 A.M.
 The principal cause of death and related causes of importance were as follows:
Fractured Hips
1867
1914
 Date of onset

Other contributory causes of importance:

Name of operation 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) Dr. J. A. Lusson, M. D.
 (Address) Mansfield Mo



Wright

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Ella Coffman
Who died at _____ on June 21 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex F Color or race W Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 76 Months 5 Days 27

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____ (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month 1 Year 1934

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Fractured Hip
Accidental

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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 Fell on floor when attempting get on step for

Nature of injury I guess it was accidental

Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

Name of physician J. H. Fuson M.D.

Address of physician Manassas Mo

Signature of Registrar Amos C. Ray

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,
E. T. McCaugh M.D.

Reg. Dist. No. 907

Primary Reg. Dist. No. 6220

Special Agent.

S-22995