

JAN 20 1937

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

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1. PLACE OF DEATH

County Waggoner
 Township Champion
 City Okemuncie (No. _____)

Registration District No. 280
 Primary Registration District No. 5891

File No. _____
 Registered No. _____
 St. _____ Ward _____

2. FULL NAME

(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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-8-1847

7. AGE YEARS 84 MONTHS 2 DAYS 12 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. 999

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) Ohio (STATE OR COUNTRY)

13. NAME Aron Maple

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

15. MAIDEN NAME Marianda Lawrey

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

17. INFORMANT Amanda Beck (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE New Hope DATE 8-22 1936

19. UNDERTAKER None (ADDRESS)

20. FILED Sept 10 1936 Jay E. Ray Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-20 1936

22. I HEREBY CERTIFY, That I attended deceased from June 9, 1936, to 8-10, 1936

I last saw her alive on 8-18, 1936. Death is said to have occurred on the date stated above, at 10:45 a.m.

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

Sensibility Date of onset _____

Other contributory causes of importance: fall injuring hip

Name of operation _____ Date of _____

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

23. If death was due to external cause (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 1936

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 accident

Nature of injury _____

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

If so, specify _____

(Signed) A. H. James, M. D.(Address) New Hope

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.

1862

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County Douglas
Township Champion
City (No.)

Registration District No. 280
Primary Registration District No. 3391

File No.
Registered No.
St. Ward)

2. FULL NAME

Angeline Coffin

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

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 mins. 94 2 12

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 Sept 10 1936 Jayle Co. Roy Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-20, 1936

22. HEREBY CERTIFY, That I attended deceased from

....., 19....., 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:

Date of onset

Other contributory causes of importance:

Fall injuring hip
at home
exact date unknown

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, 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) H. G. James, M. D.

(Address) 1111 Grove mo

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