

FILED FEB 24 1940
STANDARD CERTIFICATE OF DEATH

State File No. 1985

Registration District No. 156

Primary Registration District No. 4090

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Harrisonville Mo.
(c) Name of hospital or institution: South East Harrisonville
(d) Length of stay: In hospital or institution _____
In this community 29 years
years, months or days

8. (a) PRINT FULL NAME Charles E. Coffman

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Ma 5. Color or race wh 6. (a) Single, widowed, married, divorced W.

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 4 30 1858
(Month) (Day) (Year)

8. AGE: Years 81 Months 8 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace Putnam Co Ind.
(City, town, or county) (State or foreign country)

10. Usual occupation Wheel laborer

11. Industry or business _____

12. Name Charles Coffman

13. Birthplace Louisiana
(City, town, or county) (State or foreign country)

14. Maiden name Eleanor Bryan

15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Wallace Coffman

(b) Address Harrisonville

17. (a) Burial (b) Date thereof Jan 29 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Acadian Cem.

18. (a) Signature of funeral director Atkinson Bros

(b) Address Harrisonville Mo 845

19. (a) 1-29-40 (b) Ed Wesley M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass
(c) City or town Harrisonville
(d) Street No. in S.E. corner - No. H + No
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 27th
year 1940 hour 9 minute 45 A.M.

21. I hereby certify that I attended the deceased from 4-30-38
to 7-21 1939

that I last saw him alive on 7-21 1939
and that death occurred on the date and hour stated above.

Immediate cause of death unknown Duration _____

Due to Senility

Due to Advanced chest condition possibly tuberculous (not proven)
Other conditions Grandson died 2 years ago T.B.
(include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Ed Wesley M.D. (M. D. or other)

Address Harrisonville Mo Date signed 1-29-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.
working under my personal supervision.

Signed

Floyd W. Johnson

.....
Licensed Embalmer No. *3920*

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.