

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

2341  
Do not use this space.

FILED FEB 13 1940

1. PLACE OF DEATH

(a) County Greene Registration District No. 318  
 (b) Township \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 (c) City or Springfield, Mo. (d) Street No. Springfield Baptist Hospital St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 25 Willie O. Coggins St.  Buffalo mo.  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Effie Coggins  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-17-1885  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 54 10 24  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. farmer  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-1 19 40  
 22. I HEREBY CERTIFY, That I attended deceased from 12-21, 1939, to 1-1, 1940  
 I last saw him alive on 12-1, 1939 Death is said to have occurred on the date stated above, at 5:09 P.M.  
 The principal cause of death and related causes of importance were as follows:  
careless use of knife Date of onset  
medicasterium  
 Other contributory causes of importance: 47  
 Name of operation apertion of chest Date of 12-11-39  
 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? 2 Date of injury 12, 1939  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. 0  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) E. J. Priddy, M. D.  
 (Address) Springfield, Mo.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.  
 FATHER 13. NAME Francis Coggins  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.  
 MOTHER 15. MAIDEN NAME Manerua Judd  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.  
 17. INFORMANT (ADDRESS) Lloyd Coggins  
Buffalo mo.  
 18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Pleasant Hill DATE 1-3 1940  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) L. B. Jones  
Buffalo mo.  
 20. FILED 1/31 1940 Chas. H. George, M.D.  
 Local Registrar

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.

REVISED 1-1-68

**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.....

Licensed Embalmer No.....

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.**

X