

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.

FILED FEB 19 1940

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

2605
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 403
 (b) Township Brookings Primary Registration District No. 5557 Registered No. _____
 (c) City Raytown (d) Street No. R.C. Mo. R.F. D#2 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (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 HAROLD HENRY COFFER
 (a) Residence, No. Raytown Mo. R.C. #2 St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 1, 1937

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>0</u>	<u>8</u>	<u>12</u>	

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

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 _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Raytown, Mo.

FATHER

13. NAME Frank E. Coffey

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ray Co. Mo.

MOTHER

15. MAIDEN NAME Nellie Mearse

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Camden, Mo.

17. INFORMANT (ADDRESS) Father Frank E. Coffey R.C. Mo. R.F. D#2

18. BURIAL, CREMATION, OR REMOVAL PLACE Camden, Mo. DATE Jan. 14, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Clark H. Regent Raytown Mo.

20. FILED 1-13 19 40 M. Meubank Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-13 19 40

22. I HEREBY CERTIFY, That I attended deceased from 1-11 19 40 to 1-13 19 40
 I last saw him live on 1-13 19 40 Death is said to have occurred on the date stated above, at 6:30 a.m.
 The principal cause of death and related causes of importance were as follows:
Bronchial Pneumonia
 Date of onset 1-10-40

Other contributory causes of importance:
Bronchial Pneumonia 1-10-40
None

Name of operation _____ Date of _____
 What test confirmed diagnosis? Chest x-ray Was there an autopsy? No

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 J. L. Jefferson M. D.
 (Signed) _____ (Address) Raytown Mo.

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,

A. Clark Hegent

....., or by

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

Signed.....

A. Clark Hegent

Licensed Embalmer No.....

3983

P. O. Address.....

Raytown Mo.

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.