

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

REV. 5-17-59 1 x1981

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3788 ✓

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 134

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Pine Lawn
(c) Name of hospital or institution:
3709 Manola
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Pine Lawn
(If outside city or town limits, write "RURAL")
(d) Street No. 3709 Manola
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME John C. Coffey

8. (b) If veteran, name war None 8. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased November 26, 1858
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 1 21 hr. min.

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Charles Coffey

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

14. Maiden name Unknown

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

16. (a) Informant's own signature Mrs Ambrose Hazzard

(b) Address 5148 Northland Avenue

17. (a) Burial (b) Date thereof Jan 20, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Galvary Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address 1225 Union

19. (a) JAN 19 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 17
year 1940 hour 7 minute 15 P. M.

21. I hereby certify that I attended the deceased from Aug 9
1939 to Jan 17, 1940
that I last saw him alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Interstitial Nephritis
myocarditis
Due to arterio-sclerosis

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) 93

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 W. D. White (M. D. or other) M. D.
Address 2803 N. Knightsburg Date signed 1-18-40

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

B.C.

(Licensed Embalmer's Statement on Reverse Side)

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.....

Bernard G. Stunt

Licensed Embalmer No.....

3500

P. O. Address.....

1225 Wood Ave

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.