

MAY 13 1940

316

Registration District No.

Primary Registration District No. 2001

Registrar's No.

1. PLACE OF DEATH:  
(a) County GREENE  
(b) City or town Springfield  
(c) Name of hospital or institution: St. John Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 month  
(Specify whether years, months or days)

In this community:  
years, months or days  
3. (a) PRINT FULL NAME James Coffey  
3. (b) If veteran, name war  
3. (c) Social Security No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Unknown  
6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive years  
7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
About 78 Unknown hr. min.

9. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
10. Usual occupation Unknown

11. Industry or business  
MOTHER FATHER { 12. Name Unknown  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hospital Records  
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof April 5 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St. Mary

18. (a) Signature of funeral director H.H. Lohmeyer  
(b) Address Springfield, Mo.

19. (a) 4/4/40 (b) Chas. S. George  
(Date death local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Greene  
(c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 600 W. Pine  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. years

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 3  
year 1940 hour 2 minute 30 a.m.

21. I hereby certify that I attended the deceased from March 3, 1940 to April 1, 1940  
that I last saw him alive on April 3, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Prostatic Hypertrophy Duration 10 yrs  
Due to Senility (old age)

Due to  
Other conditions Arterio-sclerosis 10 yrs  
(Include pregnancy within 3 months of death)

Major findings: 97  
Of operations  
Of autopsy  
PHYSICIAN  
Underline the cause to which death should be charged statistically

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 Dr. Vinyard (M. D. or other)  
Address Springfield Mo Date signed 4-4-40

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.

**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.....

*Walter E. Hamilton*

Licensed Embalmer No.....

*3508*

P. O. Address.....

*Springfield Mo.*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HAND WRITING. (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