

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

18966
 Do not use this space.

1. PLACE OF DEATH

(a) County Marion Registration District No. 546
 (b) Township Johnsonson Primary Registration District No. 5735
 (c) City..... (d) Street No..... Registered No. 9
 (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. da.

2. PRINT FULL NAME

(a) Residence, No. William Golden Coffey
Wichey - Rural - Marion Co
 (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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF <u>Lucie Coffey</u> (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>May 3 - 1858</u>		
7. AGE YEARS <u>81</u>	MONTHS <u>11</u>	DAYS <u>28</u>
If LESS than 1 day, hrs. or min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Farmer</u>	
	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) <u>Feuer</u>		
FATHER	13. NAME <u>Jake Coffey</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Feuer</u>	
MOTHER	15. MAIDEN NAME <u>Hannah Domb Knauer</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Feuer</u>	
17. INFORMANT <u>Mr. J. J. Farmer</u> (ADDRESS) <u>Wichey Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Southard Cem</u> DATE <u>May 3 - 1940</u>		
19. FUNERAL DIRECTOR <u>Birmingham 485</u> (ADDRESS) <u>Wichita Mo.</u>		
20. FILED <u>May 4 - 1940</u> <u>Sam A. Warner</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 1 - 1940

22. I, HEREBY CERTIFY, That I attended deceased from April 5 1940 to May 1 1940
 last saw him alive on May 1 1940 Death is said to have occurred on the date stated above, at 8 a. m.
 The principal cause of death and related causes of importance were as follows:

Pleurisy with Effusion

Date of onset

Other contributory causes of importance:

Name of operator Chas. J. ... Date of May 19 1940
 What test confirmed diagnosis? yes Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no Date of injury May 1 1940
 Where did injury occur? Wichey (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury no
 Nature of injury no

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify

(Signed) Chas. J. ..., M. D.
 (Address) Wichey Mo.

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.

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STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No. or by, Registered Apprentice No.

working under my personal supervision.

Signed.....

Licensed Embalmer No.

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18966

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 546

Primary Registration District No. 5735-

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Johnson

(c) Name of hospital or institution: _____
(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

3. (a) PRINT FULL NAME Wm Golden Coffey

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>11</u>	<u>28</u>	_____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

{ 14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH _____ month May day 1 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____; that I last saw h. _____ alive on _____ 19____ and that death occurred on the day and hour stated above.

Immediate cause of death Pneumonia with effusion

Due to inference

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) HP

Major findings: Of operations _____

Of autopsy _____

Duration 17 days

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 O. H. Jones (M. D. or other) _____

Address Diebay mo Date signed _____

SUPPLEMENTARY

S-18966