

35772

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

BUREAU OF THE CENSUS

NOV 25 1940

Registration District No. 1149

Primary Registration District No. 5697

Registrar's No. 10

1. PLACE OF DEATH:
 (a) County McDonald
 (b) City or town Jame mo
 (c) Name of hospital or institution: none
 (d) Length of stay: In hospital or institution 2
 In this community about 62 yrs

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County McDonald
 (c) City or town Jame mo
 (d) Street No. 0
 (e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Pierce Coffee
 8. (b) If veteran, name war _____
 8. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Nov day 4
 year 1940 hour 2 minute 30 A M.

4. Sex m 5. Color or race w
 6. (a) Single, widowed, married, divorced m
 6. (b) Name of husband or wife Rate Coffee
 6. (c) Age of husband or wife if alive 56 years
 7. Birth date of deceased Dec 31 1877

21. I hereby certify that I attended the deceased from Jan 1938 to Nov 4 1940
 that I last saw him alive on _____, 19____
 and that death occurred on the date and hour stated above.
 Immediate cause of death Cerebral Circulatory
hemorrhage

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>10</u>	<u>3</u>	hr. _____ min.

Due to _____
 Due to _____

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

Other conditions None
 (Include pregnancy within 3 months of death)

10. Usual occupation Carpenter

11. Industry or business _____
 12. Name Janie Coffee
 13. Birthplace Missouri
 (City, town, or county) _____ (State or foreign country) _____
 14. Maiden name Janet Lee Clark
 15. Birthplace Missouri
 (City, town, or county) _____ (State or foreign country) _____

Major findings:
 Of operations _____
 Of autopsy 2, 4, 5

16. (a) Informant's own signature Janie Coffee
 (b) Address Jame mo
 17. (a) Burial (b) Date thereof Nov 6 1940
 (Burial, cremation, or removal) _____ (Month) (Day) (Year) _____
 (c) Place: burial or cremation Jame mo
 18. (a) Signature of funeral director Wheeler
 (b) Address Wheeler mo
 19. (a) 11-6-40 (b) Lee W. Darnell
 (Date received local registrar) _____ (Registrar's signature) _____

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?
Yes
 While at work? _____ (Specify type of place) _____
 (e) Means of injury _____
 23. Signature W. J. Hunter (M. D. or other) _____
 Address penville Date signed 11/6/40

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

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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RECEIVED

District Health Officer No. 6,

District File Number 1140-2904

Date Filed NOV 20 1940

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

Wm. Marcus Payne

Registered Apprentice No.

working under my personal supervision.

Signed *Wm. Marcus Payne*

Licensed Embalmer No. *7447*

P. O. Address *Wheaton 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.

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STANDARD CERTIFICATE OF DEATH

State File No. 35772

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 1149

Primary Registration District No. 5697

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Mc Donald
(b) City or town W. Rock Twp
(If outside city or town limits, write "RURAL" and name of township)
(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 _____
In this community _____ (Specify whether years, months or days)

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.

3. (a) PRINT FULL NAME

Pierce Coffee

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 62 Months 10 Days 3 If less than one day _____ 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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 4 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that I last saw him _____ alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Circulatory Insufficiency

Due to _____

Due to _____

Other conditions nephritis Chronic
(Include pregnancy within 3 months of death)

Major findings: 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) _____ (Means of injury)

23. Signature W. H. Hobbs (M. D. or other) _____
Address Pinellas Date signed 11-4

SUPPLEMENTARY

