

S. No. 2  
-11-10-39  
. 5-17-39  
I X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

7783

MAR 19 1941

State File No. 668

Registration District No. 668

Primary Registration District No. 3032

Registrar's No. 53

**1. PLACE OF DEATH:**  
 (a) County Pettis  
 (b) City or town Sudonia  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution Rothwell Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 6 days  
(Specify whether In this community years, months or days) 2 yrs

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State MO (b) County Pettis  
 (c) City or town Sudonia  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 904 E 3rd  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A? 0 years.

3. (a) PRINT FULL NAME JOSEPH COFFMAN

3. (b) If veteran, name war.  3. (c) Social Security No.                     

4. Sex Male 5. Color White 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Subanda Coffman 6. (c) Age of husband or wife if alive 78 years  
 7. Birth date of deceased May 2 1862  
(Month) (Day) (Year)

8. AGE: 78 Years 8 Months 29 Days If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business Owner

MOTHER FATHER  
 { 12. Name unkn  
 { 13. Birthplace unkn / Virginia  
(City, town, or county) (State or foreign country)  
 { 14. Maiden name unkn  
 { 15. Birthplace unkn / Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant Rx

(b) Address Peter Jones

17. (a) Funeral (b) Date thereof Feb 4 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pat Grove Cem

18. (a) Signature of funeral director Alvin J. Sneed

(b) Address Pat Grove, Mo

19. (a) Feb 3/41 (b) Miss Harry Sneed  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day Feb  
year 1941 hour 12 minute AM M.

21. I hereby certify that I attended the deceased from 22 Jan 1941 to Feb 1 1941  
that I last saw him alive on Feb 1 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Coronary artery  
Prostate  
Impacted  
Splenomegaly  
 Other conditions (Include pregnancy within 3 months of death)

Major findings:  
 Of operations 518  
 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?  
At home  
(Specify type of place)  
 (e) Means of injury \_\_\_\_\_  
 23. Signature J. B. Sweeney M.D. or other D  
 Address Sudonia Date signed 2/3/41

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

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

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 3-13-41

**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 Robert H. Reed  
Licensed Embalmer No. 3745  
P. O. Address Seaside

**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.**