

Registration District No. 312 Primary Registration District No. 5049

1. PLACE OF DEATH:  
(a) County: Barry McDowell Township  
(b) City or town: McDowell, Mo.  
(c) Name of hospital or institution: 2 1/2 mi. north end of McDowell  
(d) Length of stay: In hospital or institution: 1  
In this community: forty years

USUAL RESIDENCE OF DECEASED:  
(a) State: Missouri (b) County: Barry 5  
(c) City or town: Rural  
(d) Street No.: 2 1/2 mi. N-E of McDowell  
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME: Matildie J. Coffin  
3. (b) If veteran, name war: none  
3. (c) Social Security No.: none

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month: Aug day: 22 year: 1943 hour: 12 a.m. minute: 30 A.M.  
21. I hereby certify that I attended the deceased from: 19 to 19; that I last saw her alive on: did not see her 19; and that death occurred on the date and hour stated above.

4. Sex: female 5. Color or race: white 6. (a) Single, widowed, married, divorced, married  
6. (b) Name of husband or wife: William L. Coffin 6. (c) Age of husband or wife if alive: 85 years  
7. Birth date of deceased: April 11 1865

Immediate cause of death: Endo Carditis  
Duration: 2 yrs

8. AGE:	Years	Months	Days	If less than one day
	78	4	11	hr. min.

Due to: Found dead in bed.  
Other conditions: (Include pregnancy within 3 months of death)  
Major findings: Of operations: 92d  
Of autopsy:

9. Birthplace: Indiana  
10. Usual occupation: house wife  
11. Industry or business:  
12. Name: Gabere Osburn  
13. Birthplace: Indiana  
14. Maiden name: Cynthia Holloway  
15. Birthplace: Indiana

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

16. (a) Informant: Mrs. L. Coffin  
(b) Address: Verona, Mo.  
17. (a) (Burial, cremation, or removal) (b) Date thereof: Kellon Cemetery  
(c) Place: burial or cremation: Kellon Cemetery  
18. (a) Signature of funeral director: W.D. Koon  
(b) Address: Cassville, Mo.  
19. (a) 11/24/43 (b) W. Williams

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: John H. Cullen (M. D. or other) Do. by 23-  
Address: Cuba, Mo. Date signed:

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

MOTHER FATHER

RECEIVED

District Health Officer No. 0, 11

District File Number 1143-1298

Date Filed NOV 30 1943

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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. C. Koon....., Registered Apprentice No. 338  
working under my personal supervision.

Signed W. C. Koon.....

Licensed Embalmer No. 2456

P. O. Address Cassville, 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, fact should be so stated above.**