S. No. 2
M—9-4-41
v. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23460

FILED AUG 3 1945

Registration District No. ..... Primary Registration District No. 1800 Registrar's No. 798

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital No 22 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yrs 4 Mo. (Specify whether In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Gentry 11

(c) City or town Stanberry 1 (If outside city or town limits, write "RURAL")

(d) Street No. ..... 7 (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country .....

3. (a) PRINT FULL NAME George L Coffey

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex MO

5. Color or race W

6. (a) Single, widowed, married, divorced Wid 4

6. (b) Name of husband or wife .....

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

7. Birth date of deceased not given (Month) (Day) 1865 (Year)

8. AGE: Years 80 | Months — | Days — | If less than one day ..... hr. ..... min.

9. Birthplace Mo (City, town, or county) 0 (State or foreign country)

10. Usual occupation Retired Dentist

11. Industry or business .....

FATHER
12. Name not given
13. Birthplace not given (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name not given
15. Birthplace not given (City, town, or county) 0 (State or foreign country)

16. (a) Informant Record Hospital

(b) Address St Joseph Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-20-45 (Month) (Day) (Year)

(c) Place: burial or cremation Aloutheus Mo

18. (a) Signature of funeral director Laton H. Phillips

(b) Address Stanberry Mo

19. (a) 7-20-45 (Date received local registrar) (b) Helen L Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20 year 1945 hour 5 minute 15 P.M.

21. I hereby certify that I attended the deceased from 7-12, 1945, to 7-20, 1945 that I last saw him alive on 7-20, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Thrombosis	
Due to arteriosclerosis	
Due to	
Other conditions Senile Deterioration (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

94W

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? ..... (Specify type of place)

While at work? ..... (e) Means of injury 0

23. Signature C E Salzer (M. D. ~~or other~~)

Address St Joseph Mo. Date signed 7/20/45

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(Licensed Embalmer's Statement on Reverse Side)

MAR 8 1958

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 Lafayette Phillips

Licensed Embalmer No. 1898

P. O. Address Stoneham Mass.

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.