

FILED JUL 18 1945

Registration District No. **381**

Primary Registration District No. **4513**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Sullivan**

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

(c) Name of hospital or institution: **1**

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **no** (Specify whether)

In this community **None** (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Sullivan**

(c) City or town **Milan**
(If outside city or town limits, write "RURAL")

(d) Street No. **City** (If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)

If yes name country

3. (a) PRINT FULL NAME **JAMES F. Coffey**

3. (b) If veteran, name war **None**

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **30**
year **1945** hour **6:30** minute **PM**

21. I hereby certify that I attended the deceased from **Dec 1944** to **April 30 1945**
that I last saw him alive on **April 28 1945**
and that death occurred on the date and hour stated above.

4. Sex **male** 5. Color or race **white**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Dora Alice Coffey**

6. (c) Age of husband or wife if alive **18** years

7. Birth date of deceased **Apr 2 18 81**
(Month) (Day) (Year)

Immediate cause of death **Myocarditis**

Duration **4 mo.**

8. AGE: Years **63** Months **4** Days **28** If less than one day hr. min.

Due to **influenza**

Due to

9. Birthplace **W Jackson Township**
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death)

10. Usual occupation **Saw mill**

Major findings: Of operations **abd**

Of autopsy

11. Industry or business

12. Name **Geo. L. Coffey**

13. Birthplace **Mo. De Witt County**
(City, town, or county) (State or foreign country)

14. Maiden name **Rebecca Hooper**

15. Birthplace **Mo. De Witt County**
(City, town, or county) (State or foreign country)

16. (a) Informant **None**

(b) Address

17. (a) **Burial** (b) Date thereof **May 8 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Brookfield**

18. (a) Signature of funeral director **James F. Coffey**

(b) Address **Milan Mo**

19. (a) **May 4-45** (b) **Mrs. D. Green**
(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?

While at work (Specify type of place) (e) Means of injury

23. Signature **W. J. Green** (M. D. or other)

Address **Milan** Date signed **7-25**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

5
1
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1190.

RECEIVED

District Health Officer No. 10

District File Number 7-45-1179

Date Filed JUL 17 1945

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..... *Murl E. Husted*

Licensed Embalmer No. 3304

P. O. Address..... *Unionville, 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.