V.S. No. 2
100M—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35135

FILED DEC 7 1945

Registration District No. 318 Primary Registration District No. 100 Registrar's No. 10387

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: Park Lane Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 53 Days (Specify whether

In this community 10 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 12

(c) City or town St Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4930 Lindell
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Ruth Moore Coffman

3. (b) If veteran, name war —

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife James

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

7. Birth date of deceased July (Month) 21 (Day) 1915 (Year)

8. AGE: Years 30 Months 4 Days 8 If less than one day hr. min.

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

10. Usual occupation X-Ray Technician

11. Industry or business

FATHER
12. Name James W Moore
13. Birthplace Ellington (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Phoebe McNew
15. Birthplace Paragould (City, town, or county) Mo (State or foreign country)

16. (a) Informant Ruby Geissler

(b) Address 4961 Laclede

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-45 (Month) (Day) (Year)

(c) Place: burial or cremation Farmington Mo

18. (a) Signature of funeral director Cogean Und Co

(b) Address Farmington, Mo

19. (a) NOV 30 1945 (Date received local registrar) (b) J F Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 29 year 1945 hour 12 minute 25 A.M.

21. I hereby certify that I attended the deceased from 10-26- 1945 to 11-29 1945; that I last saw her alive on 11-28 1945; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Acute intestinal obstruction

Due to to torsion of mesentery

Due to

Other conditions
(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?

(Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. Name)

Address 4930 Lindell B Date signed 11/29/45

(Licensed Embalmer's Statement on Reverse Side)

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 John Ketter

Licensed Embalmer No. 3880

P. O. Address Ottawa Kans

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35135

Registration District No. 318 Primary Registration District No. 100 Registrar's No. 10387

1. PLACE OF DEATH:

(a) County
(b) City or town St Louis (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Park Lane Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 53 DAYS (Specify whether years, months or days)
In this community 10 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St Louis (If outside city or town limits, write "RURAL")
(d) Street No. 4930 Lindell (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Ruth Burnell Moore Coffman

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow Divorced

6. (b) Name of husband or wife ~~James~~ John Eckles Coffman 6. (c) Age of husband or wife if alive years

7. Birth date of deceased July (Month) 21 (Day) 1915 (Year)

8. AGE: Years 30 Months 4 Days 8 If less than one day hr. min.

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

10. Usual occupation X-Ray Technician

11. Industry or business

MOTHER FATHER

12. Name James W Moore
13. Birthplace Ellington (City, town, or county) Mo (State or foreign country)
14. Maiden name Phoebe McNew
15. Birthplace Paragould (City, town, or county) Mo (State or foreign country)

16. (a) Informant Ruby Geissler
(b) Address 4961 Fiedede

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-45 (Month) (Day) (Year)

(c) Place: burial or cremation Farmington Mo

18. (a) Signature of funeral director Cogan and Co
(b) Address Farmington Mo

19. (a) NOV 30 1945 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 29 year 1945 hour 12 minute 25 A.M.

21. I hereby certify that I attended the deceased from 10-26- 1945 to 11-29- 1945 that I last saw her alive on 11-28 1945 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Acute intestinal obstruction
Due to Torsion of Mesentery
Due to
Other conditions (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? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Date signed 11/29/45
Address

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
Items 13a, 6a, b amended by affidavit of funeral home 10-12-95