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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 13 1947
Registration District No. 168

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1620
Registrar's No. 95

Primary Registration District No. 4258

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

1. PLACE OF DEATH:
(a) County Knox
(b) City or town Edina
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Life. (Specify whether)
In this community Life. years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Knox 52
(c) City or town Edina (If outside city or town limits, write "RURAL") 1
(d) Street No. 0 (If rural, give location) 0
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Joseph Coffey
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Anna Laubscher
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased FEB - 20 - 1877
(Month) (Day) (Year)

8. AGE: Years 69 Months 11 Days 11
If less than one day hr. min.

9. Birthplace Knox County Missouri. (City, town, or county) (State or foreign country)
10. Usual occupation Farmer. Retired.

11. Industry or business
12. Name Micheal Coffey
13. Birthplace Knox City Missouri (City, town, or county) (State or foreign country)
14. Maiden name Cordella McCoy
15. Birthplace Knox County Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Joseph Coffey
(b) Address Edina, Mo.

17. (a) Burial (b) Date thereof Feb-3-1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Linville, Edina, Mo.

18. (a) Signature of funeral director Keith Hudson
(b) Address Edina, Mo.

19. (a) 2-3-47 (b) Welf. S. Hunselt
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 31 year 1947 hour 9:00 PM minute 0 M.
21. I hereby certify that I attended the deceased from Sept 13 to Jan 31, 1947
that I last saw him alive on Jan 31, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 15 yrs.

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)
Major findings: Q3P
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?

While at work? (Specify type of place) (e) Means of injury 2

23. Signature Edwin J. ... (M. D. or other)
Address Edina, Mo. Date signed 2/2/47

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RECEIVED
District Embalmer No. 47-312
Filed - FEB-1-2-1947
WYKE V

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 Keith Hudson

Licensed Embalmer No. 2415

P. O. Address Edina, Missouri

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 CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *Feb*Registration District No. *169*Primary Registration District No. *4258*Registrar's No. *95*

1. PLACE OF DEATH:

(a) County *Knox*
 (b) City or town *Edina*
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

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

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

In this community _____ years, months or days)

3. (a) PRINT FULL NAME

Joseph Coffey

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex *m*5. Color or race *w*6. (a) Single, widowed, married, divorced *m*

6. (b) Name of husband or wife _____

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

7. Birth date of deceased *Feb 20*

(Month)

(Day)

(Year)

8. AGE:

Years *69*

Months

Days

If less than one day

...hr. ...min.

9. Birthplace _____

(City, town, or county)

(State or foreign country) *mo*

10. Usual occupation _____

11. Industry or business _____

MOTHER, FATHER { 12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal)

(b) Date thereof _____

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *Feb 3-47* (Date received local registrar)(b) *Neil S. Nemeth* (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *mo* (b) County *Knox*
 (c) City or town *Edina*
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year *1947* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

Due to _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—PERMANENT RECORD

SUPPLEMENTARY

S-1620