

No. 2
-1/47
5-17-39

FILED AUG 11 1947
Registration District No. **46**

Primary Registration District No. **1000**

Registrar's No. **906**

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: **2401 So. 2nd. St.**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **None** (Specify whether)

In this community **Lifetime**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**

(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")

(d) Street No. **2401 So. 2nd. St.**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country *****

3. (a) PRINT FULL NAME **Mathew Coffey**

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

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

4. Sex **Male** 5. Color or race **White**

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

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

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

7. Birth date of deceased **February 24 1880**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
J	67	5	5hr.min.

9. Birthplace **St. Joseph Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Foreman**

11. Industry or business **Armour & Co Hog Cooler**

12. Name **Joseph Coffey**

13. Birthplace **Unknown Ireland**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary O'Rourke**

15. Birthplace **Unknown Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **William Coffey**

(b) Address **3624 W. 105th. St. Chicago**

17. (a) **Burial** (b) Date thereof **Aug. 1, 47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Olivet Cemetery**

18. (a) Signature of funeral director **Norman W. Sidenfeller**

(b) Address **1802 Union St. St. Joseph, Mo.**

19. (a) **8-4-47** (b) **W. L. Jenkins**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **29**
year **1947** hour **7** minute **30 P. M.**

21. I hereby certify that I attended the deceased from **July 29**, 19**47** to **July 29**, 19**47** that I last saw him alive on **July 29**, 19**47** and that death occurred on the date and hour stated above.

Immediate cause of death **cardiac occlusion** **3 hrs**

Due to **arteriosclerosis** **5 yrs**

Due to

Other conditions **✓**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **✓**

Of autops: **✓**

Duration

PHYSICIAN

Underline the cause of 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) () Means of injury **✓** ()

23. **Charles H. Werner** (M. D. or other) **7-31-1947**
221 Kirkpatrick Bldg. Date signed

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

MOTHER FATHER

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.....

Robert L. Gaylor

Licensed Embalmer No. 3308

P. O. Address..... *St Joseph, 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.