

3. No. 2
1-8-43
5-17-39
1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 20 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27095

Registration District No. 78

Primary Registration District No. 5286

Registrar's No. 27

1. PLACE OF DEATH

(a) County Clark
(b) City or town ~~Wray~~
(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
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Clark
(c) City or town Wray
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country?
If yes, name country

3. (a) PRINT FULL NAME Ella Maria Coffin

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
6. (b) Name of husband or wife Millard Coffin
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June 10 - 1859

8. AGE: Years 88 Months 2 Days 3
If less than one day hr. min.

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

10. Usual occupation Housekeeper

11. Industry or business

12. Name Abraham Christy
13. Birthplace Ohio
14. Maiden name Elizabeth Warner
15. Birthplace Ohio

16. (a) Informant Mable Coffin
(b) Address Wray Mo.

17. (c) Burial (d) Date thereof Aug. 16 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(e) Place: burial or cremation Christy B. - Repto Mo.

18. (a) Signature of funeral director
(b) Address

19. (a) State received local registrar (b) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 13
year 1947 hour 7 minute 20 P.M.
21. I hereby certify that I attended the deceased from 4-10-47
to 19 to 19
that I last saw him alive on 8-13-1947
and that death occurred on the date and hour stated above.

Immediate cause of death
CEREBRAL HEMORRHAGE
Duration
Due to
Due to
Other conditions
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?
(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
Address Date signed

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

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VS JUN 6 1960
RECEIVED
District Health Officer No. 10
District File No. 8-47-1055
Date Filed AUG 19 1947

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 Otis L. Lutting
Licensed Embalmer No. 29657
P. O. Address Lurray, 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.