

No. 2
 18-43
 17-39
 157823

Registration District No. **212**

Primary Registration District No. **3044**

Registrar's No. **50**

1. PLACE OF DEATH:

(a) County: **Miller**
 (b) City or town: **Bedou**
 (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 _____ (Specify whether
 years, months or days)
 In this community _____

3. (a) PRINT FULL NAME: MARY ELIZABETH COFFMAN

3. (b) If veteran, name war: **No**
 3. (c) Social Security No.: **NO**

4. Sex: **Female**
 5. Color or race: **White**
 6. (a) Single, widowed, married, divorced: **Widowed**
 6. (b) Name of husband or wife: **John Coffman**
 6. (c) Age of husband or wife if alive: _____ years
 7. Birth date of deceased: **Sept 7 1866**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	81	5	11	hr. _____ min.

9. Birthplace: **Webster, Co., Iowa**
 (City, town, or county) (State or foreign country)

10. Usual occupation: **Housewife**

11. Industry or business: _____

12. Name: **Daniel Stark**

13. Birthplace: **Ut**
 (City, town, or county) (State or foreign country)

14. Maiden name: **Sarah Stark**

15. Birthplace: **Ut**
 (City, town, or county) (State or foreign country)

16. (a) Informant: **Family Records**

(b) Address: _____

17. (a) **Burial** (b) Date thereof: **9-20-1947**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Bedou Cemetery**

18. (a) Signature of funeral director: **Wendy D. Phillips**
 (b) Address: **Bedou, Mo**

19. (a) **9-20-47** (b) **Wendy D. Phillips**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Mo.** (b) County: **Miller 66**
 (c) City or town: **Bedou 1**
 (If outside city or town limits, write "RURAL")
 (d) Street No.: _____ (If rural, give location) **1**
 (e) Citizen of foreign country? _____ (Yes or No) **0**
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **18**
 year **1947** hour **7** minute _____ P., M.

21. I hereby certify that I attended the deceased from **Sept 17** 19**47** to **Sept 18** 19**47**
 that I last saw her alive on **Sept 18** 19**47**
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Intestinal Obstruction** Duration **36 hrs.**

Due to _____

Due to _____

Other conditions: _____ (Include pregnancy within 3 months of death)

Major findings: _____ Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following information:
 (c) 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)
 (c) Means of injury _____

23. Signature: **W. E. Purcell** (M. D. or other) **2**
 Address: **Bedou, Mo** Date signed: **9/20/47**

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

RECEIVED
District Health Officer No. 9,
District File Number 9-30-47
Date Filed

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.....

working under my personal supervision.

Jessie D. Kelly

Registered Apprentice No.....

Signed.....

Jessie D. Kelly

Licensed Embalmer No.....

P. O. Address.....

*2663
Cedar*

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.

Registration District No. 212 Primary Registration District No. 3044

1. PLACE OF DEATH:
(a) County Miller
(b) City or town Eldon
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Mary E. Coffman
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 7 1861
(Month) (Day) (Year)

8. AGE: Years 81 Months 5 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

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

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

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (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 CERTIFICATE FROM _____
20. DATE OF DEATH: Month _____ Day _____
year 1948 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, and that I saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to Metastatic Carcinoma of Colon
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

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 _____

SUPPLEMENTARY

WRITE PLAINLY

MOTHER-FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

S-318521