

FILED JAN 30 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Coffelt
State File No. 821
Registrar's No. 61

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u> 6396	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1051 E. Dale St.</u>		d. STREET ADDRESS (If rural, give location) <u>1051 E. Dale St.</u> 0	
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARTHA</u> b. (Middle) <u>ALMEDA</u> c. (Last) <u>JONES</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>January 20 1950</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>January 12, 1879</u>
9. AGE (In years last birthday) <u>71</u> Months <u>0</u> Days <u>8</u>		IF UNDER 1 YEAR Days <u>8</u> IF UNDER 10 HRS. Hours <u>8</u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>James Jones</u>		13b. MOTHER'S MAIDEN NAME <u>Mary E. Griffin</u>	14. NAME OF HUSBAND OR WIFE _____
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Ernest Robertson</u> ADDRESS <u>Byrdton, Mo.</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u> ANTECEDENT CAUSES DUE TO (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Right Hemiparesis</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>5-24</u> , 19 <u>47</u> , to <u>1-20</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>1-20</u> , 19 <u>50</u> , and that death occurred at <u>10:30 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Remond O. Coffelt</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>Springfield, Mo.</u>	23c. DATE SIGNED <u>1-21-50</u>
24a. BURIAL, CREMATION (REMOVAL method) <u>Burial</u>		24b. DATE <u>Jan. 23, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>
24d. LOCATION (City, town, or county) (State) <u>Per Co Mo.</u>			
DATE REC'D BY LOCAL REG. <u>1-24-50</u>		REGISTRAR'S SIGNATURE <u>W. J. Handley</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Brim Funeral Home</u>		ADDRESS <u>Ark Grove Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Warren D. Hottel

Signed _____

Student Embalmer

Licensed Embalmer No. *4005*

P. O. Address *25th Avenue No.*

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.