

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005120

STATE FILE NUMBER

FILED MAR 2 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 183

300
1-57 C

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>Lawrence</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		c. CITY OR TOWN <u>Aurora</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Burge Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>19 W. Pleasant</u>	
Length of stay in lb <u>1 day</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LADY</u> Middle <u>B.</u> Last <u>COFER</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>20</u> Year <u>1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 1, 1979</u>
9. AGE (In years last birthday) <u>20</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Milling Co.</u>	11. BIRTHPLACE (City and state or country) <u>Hopkinsville, Ky.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>(Unk Known) Cofer</u>	
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
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. <u>None</u>	17. INFORMANT Address <u>Sam Jackson, Aurora, Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe dehydration and electrolyte imbalance</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week?</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>vomiting--cause undetermined</u>			10 days.
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>7841</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>18 February 1959</u> , to <u>20 Feb. 1959</u> and last saw her alive on <u>20 Feb. 1959</u> Death occurred at <u>2:47 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W. Clunson, M.D.</u>		22b. ADDRESS <u>Medical Arts Building Springfield, Mo.</u>	22c. DATE SIGNED <u>2/23/59</u>
23a. BURIAL/CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/22/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Aurora, Missouri</u>
24. FUNERAL DIRECTOR <u>Arnold's Funeral Home:</u> ADDRESS <u>Aurora, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-24-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAR 5 1959

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.

Student
Signature of Student Embalmer

Signed *Irwin R. Arnold*

Licensed Embalmer No. *4929*

P. O. Address *A. S. Ross, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.