

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020906

STATE FILE NUMBER

FILED JUN 30 1959

Registration District No. 114

Primary Registration District No. 5432

Registrar's No. 18

S. 300
v. 1-57

| | | | |
|---|-----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY FRANKLIN | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE MISSOURI b. COUNTY FRANKLIN | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN MERAMEC | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN SULLIVAN Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION R. R. 2, SULLIVAN | | Length of stay in lb 3 YRS. | d. STREET ADDRESS (If outside, give location) R. R. 2 Hi-WAY 155 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last BERT EBER COFFMAN | | | 4. DATE OF DEATH Month Day Year JUNE 24 1959 |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH DEC. 18, 1901 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING | | 10b. KIND OF BUSINESS OR INDUSTRY FARM | 9. AGE (In years last birthday) 57 IF UNDER 1 YEAR: Months 6 Days 6 Hours 6 Min. 11. BIRTHPLACE (City and state or country) CRAWFORD Co., Mo. |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13a. FATHER'S NAME ADDIE COFFMAN | |
| 13b. MOTHER'S MAIDEN NAME ISABELLE WYMER | | 14. NAME OF HUSBAND OR WIFE LAURA TOURVILLE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | 17. INFORMANT LAURA COFFMAN, SULLIVAN, Mo. Address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epidemioid Carcinoma of lung | | | INTERVAL BETWEEN ONSET AND DEATH 4 months |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchitis & Emphysema | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 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.) 16 3X | |
| 20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____ | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 Sept 19 58 to June 24 59 and last saw him alive on June 24 - 1959 Death occurred at 2:00 P on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Robert McFarland MD | | 22b. ADDRESS Sullivan Mo. | 22c. DATE SIGNED June 26 - 59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE JUNE 27, 1959 | 23c. NAME OF CEMETERY OR CREMATORY V.O.O.F. MEMORIAL CEM. | 23d. LOCATION (City, town, or county) (State) SULLIVAN Mo. |
| 24. FUNERAL DIRECTOR Hartman Sullivan, Mo. ADDRESS | | 25. DATE RECD. BY LOCAL REG. 6/26/59 | 26. REGISTRAR'S SIGNATURE Thomas G. Dempsey |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

FORM 08 1137

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 *Herriem M. Eaton*

Licensed Embalmer No. *4192*
P. O. Address *Sullivan, 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.