

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-029613

FILED VS SEP 15 1959

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 134

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Laclede</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Laclede</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Lebanon</b>		Length of stay in 1b <b>78 yrs.</b>		c. CITY OR TOWN <b>Lebanon</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Long Nursing Home 175 Morton Road</b>			d. STREET ADDRESS (If outside, give location) <b>Route #1</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Arthur Asbel Coffman</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>Sept. 10, 1959</b>			
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>5-6-1881</b>	<b>9. AGE</b> (last birthday) <b>78</b>	IF UNDER 1 YEAR Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>farming</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Lebanon, Mo.</b>			
<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>		<b>13a. FATHER'S NAME</b> <b>Acie Coffman</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Mary E. Connor</b>			
<b>14. NAME OF HUSBAND OR WIFE</b> <b>deceased</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>					
<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		<b>17. INFORMANT</b> Address <b>Mrs. Bernice Bolles, Lebanon, Mo.</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> DUE TO (b) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <b>Senility</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 days.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>20b. SUICIDE</b> <input type="checkbox"/>	<b>20c. HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> <b>8/21/59 to 9/10/59</b>		<b>20g. COUNTY STATE</b> <b>Lebanon Mo</b>			
<b>21. I attended the deceased from</b> <b>8:25 A.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <b>J. H. Johnson MD</b>				<b>22b. ADDRESS</b> <b>Lebanon Mo</b>			
<b>22c. DATE SIGNED</b> <b>9-12-59</b>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>burial</b>		<b>23b. DATE</b> <b>9-13-59</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>White Oak Pond</b>			
<b>23d. LOCATION</b> (City, town, or county) (State) <b>Laclede County, Missouri</b>							
<b>24. FUNERAL DIRECTOR</b> <b>T. J. Shadel</b>		ADDRESS <b>Lebanon, Mo.</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>9-12-1959</b>	<b>26. REGISTRAR'S SIGNATURE</b> <b>Hella L. Hays</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Walter C. Simpson

Licensed Embalmer No. 5071

P. O. Address Hartwell, Ga.

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.

B-51-P

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