

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031502

FILED VS OCT 13 1959

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1007 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY DeKalb					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 1 day		c. CITY OR TOWN Maysville		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Meth. Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle RAY Last COFFEY				4. DATE OF DEATH Month Sept. Day 28, Year 1959					
5. SEX male		6. COLOR OR RACE white		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10/15/1939		9. AGE (last birthday) 19 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer			10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (City and state or country) Savannah, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Austin Coffey			13b. MOTHER'S MAIDEN NAME Marjorie Brunk			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) no			16. SOCIAL SECURITY NO. unknown		17. INFORMANT Austin Coffey, Maysville, 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) Cranio-cerebral trauma--severe							INTERVAL BETWEEN ONSET AND DEATH 1 day		
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)						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			
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.) Auto accident					
20c. TIME OF INJURY Hour 10 a.m. 9-27-1959 p.m.									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway		20f. CITY, TOWN, OR LOCATION 3 mi. W. Maysville		COUNTY DeKalb		STATE Mo.	
21. I attended the deceased from 9/27/59 to 9/28/59 and last saw her/him alive on 9/28/59				Death occurred at 12:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) William B. Lockhart, M.D.				22b. ADDRESS 902 Edmond, St. Joseph, Mo.			22c. DATE SIGNED 9/28/59		
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 9/28/1959		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) Maysville Missouri		(State)	
24. FUNERAL DIRECTOR Heaton-Bozman			ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Oct. 8, 1959		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell		

DOCUMENT

W. G. Lockhart, M.D. Certification

BY AFFIDAVIT OF

VS OCT 14 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William Spalding

Licensed Embalmer No. 4535

P. O. Address St Joseph

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.