

FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
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U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 3 2 5

XC-10 450 628 SL 21627 FILED VS DEC 21 1959

211295

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY FAYETTE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. Grand, St. Louis, Mo.		c. CITY OR TOWN Vandalia	
Length of stay in 1b 8 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Veterans Adm. Hospital		d. STREET ADDRESS (If outside, give location) - - - - -	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First CHARLES Middle S. Last COFFEY			4. DATE OF DEATH Month DECEMBER Day 5 Year 1959		
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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 8/25/02	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OOD Jobs	10b. KIND OF BUSINESS OR INDUSTRY HIMSELF	11. BIRTHPLACE (City and state or country) RUSSELL SPRINGS, KY.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME GEORGE COFFEY	13b. MOTHER'S MAIDEN NAME MINNIE HUGHES	14. NAME OF HUSBAND OR WIFE - - - - -
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT VA HOSP. RECORDS, ST. LOUIS, MO.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF PANCREAS, GENERALIZED		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
DUE TO (b) _____		157x
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	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)	
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
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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.) VA	20f. CITY, TOWN, OR LOCATION VAH, ST. LOUIS, MO.	COUNTY _____ STATE _____
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21. I attended the deceased from **11/27/59** to **12/5/59** and last saw him alive on **12/5/59**
 Death occurred at **5:13 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) A. K. FARRUCK, M.D.	22b. ADDRESS VAH, ST. LOUIS, MO.	22c. DATE SIGNED 12-5-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) 12-5-59	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY SOUTH HILL	23d. LOCATION (City, town, or county) (State) VANDALIA, ILLINOIS
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24. FUNERAL DIRECTOR John A. Gowski, East St. Louis, Mo	25. DATE RECD. BY LOCAL REG. DEC 6 1959	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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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 John A. Czeski
Licensed Embalmer No. 3398
P. O. Address _____

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.