

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003257

FILED VS. FEB 5 1960

Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 956**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>				Length of stay in 1b		c. CITY OR TOWN <b>POTOSI</b>		
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1120 NO. MISSOURI</b>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>LUCILLE C. COFFMAN</b>				4. DATE OF DEATH Month Day Year <b>JANUARY 26 1960</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5/19/97</b>		
9. AGE (last birthday) <b>62</b>		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (City and state or country) <b>CADET, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		
13a. FATHER'S NAME <b>ZENO PORTELL</b>			13b. MOTHER'S MAIDEN NAME <b>LUCINDA CHRISTPHOR</b>			14. NAME OF HUSBAND OR WIFE <b>RAYMOND COFFMAN</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>DALEY POLITTE, 106a JACKSON, POTOSI</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO (b) <b>CORONARY THROMBOSIS</b> DUE TO (c) <b>420.1</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b> <b>1 WEEK</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 checked="" 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.)				
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 <b>JAN. 22, 1960</b> to <b>JAN. 26, 1960</b> and last saw her/him alive on <b>JAN. 26, 1960</b> Death occurred at <b>9:26 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>C. D. Vermillion, M. D.</b>				22b. ADDRESS <b>BARNES HOSPITAL</b>			22c. DATE SIGNED <b>1/27/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1/29/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW MASONIC</b>		23d. LOCATION (City, town, or county) <b>POTOSI, MISSOURI</b>		
24. FUNERAL DIRECTOR ADDRESS <b>OMAN JENKINS POTOSI, MISSOURI</b>				25. DATE RECD. BY LOCAL REG. <b>JAN 27 1960</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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STATEMENT BY LICENSED EMBALMER

**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 N. Shipman

Licensed Embalmer No. 4881

P. O. Address Bismarck

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.