

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031064

FILED VS SEP 12 1960

Registration District No. 155 Primary Registration District No. 5578 Registrar's No. 148

STATE FILE NUMBER

| | | | | | | | | |
|--|--|---|--|---|---|---|--|-------|
| 1. PLACE OF DEATH a. COUNTY Jasper | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Joplin Twsp. | | Length of stay in 1b 20 yrs | | c. CITY OR TOWN Joplin | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hope Manor Rest Home | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 406 N. Sergeant | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ELLA CRUTTON COFFMAN | | | | 4. DATE OF DEATH Month Day Year Sept. 4, 1960 | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 10-30-1866 | 9. AGE (last birthday) 93 | 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) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (City and state or country) Kentucky | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Joseph C. Edwards | | | 13b. MOTHER'S MAIDEN NAME Katherine Bohonson | | | 14. NAME OF HUSBAND OR WIFE Chas. C. Coffman, | | |
| 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 Address Mrs. Lillian Ford, 406 N. Sergeant, Joplin, Mo. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Bil | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive cardiac vascular disease 2 years | | | | | | | | |
| 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 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 a.m. p.m. | | Month, Day, Year | | | | | | |
| 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 Aug 27, 1960 to Sept 4, 1960 and last saw her alive on Aug 27-1960 Death occurred at 5 A m on the date stated above, and to the best of my knowledge from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Lewis H Ferguson M.D. | | | | 22b. ADDRESS 201 Med Arts - Joplin Mo. | | | 22c. DATE SIGNED 9-5-60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 9-6-60 | 23c. NAME OF CEMETERY OR CREMATORY White Oak Pond | | 23d. LOCATION (City, town, or county) Lebanon, Mo. | | (State) | | |
| 24. FUNERAL DIRECTOR ADDRESS STEVE PARKER MORTUARY, Joplin, Mo. | | | | 25. DATE RECD. BY LOCAL REG. 9-6-60 | | 26. REGISTRAR'S SIGNATURE Mrs. Madeline Switzer | | |

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 F. M. Jones

Licensed Embalmer No. 2319

P. O. Address Japhin Dr

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.