

# R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED 13 NOV 7 1960

-60-037590  
STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1155

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Easton</u>		Length of stay in 1b <u>75 Yrs</u>		c. CITY OR TOWN <u>Easton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>None</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ELIZA</u> Middle _____ Last <u>JEFFERS</u>				4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>4-3-1877</u>	9. AGE (last birthday) <u>83</u>	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) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>Harrison Co. Ky.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Quintes Coffey</u>			13b. MOTHER'S MAIDEN NAME <u>Frances Blackley</u>			14. NAME OF HUSBAND OR WIFE <u>George</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Della Divelbiss Hemple, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial insufficiency</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 mos</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) <u>Senility</u>							
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.)			
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 <u>Sept 1960</u> to <u>Oct 30, 1960</u> and last saw her <u>him</u> alive on <u>10-30-60</u> Death occurred at <u>3:15 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>E. D. Davis, M.D.</u> (Degree or title)				22b. ADDRESS <u>Stewartsville, Mo</u>		22c. DATE SIGNED <u>10-31-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-1-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Freeman Capel Cemetery</u>		23d. LOCATION (City, town, or county) <u>Easton, Mo.</u>		(State)
24. FUNERAL DIRECTOR <u>H.O. Sidenfaden &amp; Son</u> <u>RXy</u>			ADDRESS <u>St Joseph Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 2, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Charles Sandell</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*Dr. J. J. J.*

**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 *Robert J. Gaper*  
Licensed Embalmer No. 3308

P. O. Address St. Joseph, Mo.

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.