

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-030363

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 97

FILED SEP 11 1962

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Clay</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Clay</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Excelsior Springs</b>		Length of stay in 1b <b>30 yrs.</b>	c. CITY OR TOWN <b>Excelsior Springs</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Spa-View Health Haven</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>211 1/2 S. Marquette</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Effie</b> Middle <b>June</b> Last <b>Coffman</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>3,</b> Year <b>1962</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10/4/1880</b>
9. AGE (last birthday) <b>81</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife &amp; Cook V.A.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital Ex. Spgs</b>	11. BIRTHPLACE (City and state or country) <b>Newtown, MO.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Marian Deeds</b>	
13b. MOTHER'S MAIDEN NAME <b>Molly Hayward</b>		14. NAME OF HUSBAND OR WIFE <b>Charles W. 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. <b>unknown</b>	17. INFORMANT <b>Beryl Golden Coffman, Ex. Spgs. MO</b> 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) <b>Medullary Failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>None</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Thrombotic Encephalomalacia</b>			<b>6 days</b>
DUE TO (c) <b>Arteriosclerosis &amp; Diabetes Mellitus</b>			<b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Carcinoma of Rectum</b>			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 <b>6:4</b> Month, Day, Year <b>1958</b>	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>1958</b> to <b>9-3-62</b> and last saw her <b>alive</b> on <b>9-3-62</b> . Death occurred at <b>6:4</b> <b>6:45 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>C. F. Lambert MD</b> (Degree or title)		22b. ADDRESS <b>121 Excelsior St Excelsior Springs, MO</b>	22c. DATE SIGNED <b>9-4-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>9/4/1962</b>	23c. NAME OF CEMETERY <b>Bracket Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Newtown, Missouri</b>
24. FUNERAL DIRECTOR <b>Hope Funeral Home, Ex. Spgs. MO.</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>9/4/62</b>	26. REGISTRAR'S SIGNATURE <b>Caroline Hutchings</b>

USE BLACK INK OR TYPEWRITER RIBBON

Permit permit issued 9/14/62, B. H.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Chas. Virgil Hope

Licensed Embalmer No. 3950

P. O. Address Excelsior Springs, Mo.

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.