

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

35133

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City..... (No. 3836 Wyoming)

File No. 10115
Registered No. 10115
St. Ward)

2. FULL NAME

Asahel J. Coffin
(a) Residence. No. 3826 Wyoming St. 16 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male | 4. COLOR OR RACE White | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (Or) WIFE of _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 30 - 1887

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
41 | 6 | 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Real Estate
(c) Name of employer Self

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Asahel J. Coffin

11. BIRTHPLACE OF FATHER (CITY OR TOWN) New York
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Jennie Joseph

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Missouri

14. INFORMANT Mrs J. Coffin
(Address) 3826 Wyoming

15. FILED Oct 15 1923 Naub Stanseloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 12 1923

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at..... m.
Dr. P.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
93L (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) None (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

8. DID AN OPERATION PRECEDE DEATH..... DATE OF.....
WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....
13/14 (Signed) Dr. J. B. Hill, M. D.
14, 1923 (Address) Cornell

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Park Lawn Cem DATE OF BURIAL Oct 15 1923

20. UNDERTAKER Ward & Schmidt ADDRESS 3714 S. Grand

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH CARE

