

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

Do not use this space.

41773

PLACE OF DEATH

County Sullivan
Township Proctor
City Milan (No. _____ St. _____ Ward)

Registration District No. 852
Primary Registration District No. 4318

File No. _____
Registered No. 45

2. FULL NAME

Pequita Mariline Coffman
(a) Residence. No. _____ St. _____ 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 20 1930

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	0	1	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Milan
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Muel Coffman

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Sullivan Co.
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Loa White

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

14. INFORMANT Muel Coffman
(Address) Milan Mo.

15. FILED 2-26-30 Pequita McClary
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 23 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1930, to Dec. 23, 1930 that I last saw her alive on Dec. 23, 1930, and that death occurred, on the date stated above, at 3:14 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho-Pneumonia
1074
(duration) _____ yrs. _____ mos. 5 ds.
CONTRIBUTORY (SECONDARY) 100a
(duration) _____ yrs. _____ mos. _____ ds.

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) H. G. Garner M. D.
1224, 1930 (Address) Milan, Mo.

*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 Thos Union Cem. Sub 24th St. Mo. DATE OF BURIAL Dec 24 1930

20. UNDERTAKER C. A. Schwere ADDRESS Milan Mo.

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

41773
22 1930

