

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **17738**
Registrar's No. **122**

Registration District No. **4**

Primary Registration District No. **3001**

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Kirkville mo**
(c) Name of hospital or institution: **Laughter Hospital**
(d) Length of stay: In hospital or institution **16 days**
In this community **16 days**

8. (a) PRINT FULL NAME **Jasper Peter Coffin**
8. (b) If veteran, name war **no**
3. (c) Social Security No. **none**

4. Sex **Male** 5. Color or race **white**
6. (b) Name of husband or wife **Mary Louella Coffin**
7. Birth date of deceased **Oct 11 1863**

8. AGE: **76** Years Months **6** Days **29**
If less than one day hr. min.

9. Birthplace **Unionville Iowa**

10. Usual occupation **Carpenter**

11. Industry or business
12. Name **Jonathan A. Coffin**
13. Birthplace **No. Carolina**
14. Maiden name **Mary Hedgecock**
15. Birthplace **No. Carolina**

16. (a) Informant **Mrs. J. P. Coffin**
(b) Address **Moravia, Iowa**

17. (a) **Interred** (b) Date thereof **May 28/40**
(c) Place: burial or cremation **Moravia Cem.**

18. (a) Signature of funeral director **Allen Spence**
(b) Address **Adair Iowa**

19. (a) **May 25/40** (b) **Spencer L. Freeman**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Iowa** (b) County **Appanoose**
(c) City or town **Moravia**
(d) Street No. **Webosh Ave**
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **24**
year **1940** hour **10** minute **40** P. M.
21. I hereby certify that I attended the deceased from **May 9**
1940, to **May 24**, **1940**;
that I last saw him alive on **May 24**, **1940**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Jaundice due to obstruction of bile ducts**
Due to **Cancer of ducts (liver)**
Due to

Other conditions **HB**
(Include pregnancy within 3 months of death)

Major findings: **Same as above**
Of operations
Of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

3 While at work? (Specify type of place) (c) Means of injury
23. Signature **Thos W. Laughter** (M. D. or other) **DO**
Address **Hickman Mo** Date signed **May 25**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 6-40-63-24

Date Filed JUN 13 1940

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.